TITLE VI—MEDICAID AND SCHIP

Subtitle A—Medicaid

CHAPTER 1—PAYMENT FOR PRESCRIPTION DRUGS

SEC. 6001. FEDERAL UPPER PAYMENT LIMIT FOR MULTIPLE SOURCE DRUGS AND OTHER DRUG PAYMENT PROVISIONS.

(a) MODIFICATION OF FEDERAL UPPER PAYMENT LIMIT FOR MULTIPLE SOURCE DRUGS; DEFINITION OF MULTIPLE SOURCE DRUGS.—Section 1927 of the Social Security Act (42 U.S.C. 1396r–8) is amended—

(1) in subsection (e)(4)—

(A) by striking ''The Secretary'' and inserting ''Subject to paragraph (5), the Secretary''; and

(B) by inserting ''(or, effective January 1, 2007, two or more)'' after ''three or more'';

(2) by adding at the end of subsection (e) the following new paragraph:

''(5) USE OF AMP IN UPPER PAYMENT LIMITS.—Effective January 1, 2007, in applying the Federal upper reimbursement limit under paragraph (4) and section 447.332(b) of title 42 of the Code of Federal Regulations, the Secretary shall substitute 250 percent of the average manufacturer

price (as computed without regard to customary prompt pay discounts extended to wholesalers) for 150 percent of the published price.'';

(3) in subsection (k)(7)(A)(i), in the matter preceding subclause (I), by striking ''are 2 or more drug products'' and inserting ''at least 1 other drug product''; and

(4) in subclauses (I), (II), and (III) of subsection (k)(7)(A)(i), by striking ''are'' and inserting ''is'' each place it appears.

(b) DISCLOSURE OF PRICE INFORMATION TO STATES AND THE PUBLIC.—Subsection (b)(3) of such section is amended—

(1) in subparagraph (A)—

(A) in clause (i), by inserting ''month of a'' after ''last day of each''; and

(B) by adding at the end the following: ''Beginning July 1, 2006, the Secretary shall provide on a monthly basis to States under subparagraph (D)(iv) the most recently reported average manufacturer prices for single source drugs and for multiple source drugs and shall, on at least a quarterly basis, update the information posted on the website under subparagraph (D)(v).''; and

(2) in subparagraph (D)—

(A) by striking ''and'' at the end of clause (ii);

(B) by striking the period at the end of clause (iii) and inserting a comma; and

(C) by inserting after clause (iii) the following new clauses:

''(iv) to States to carry out this title, and

''(v) to the Secretary to disclose (through a website accessible to the public) average manufacturer prices.''.

(c) DEFINITION OF AVERAGE MANUFACTURER PRICE.—

(1) EXCLUSION OF CUSTOMARY PROMPT PAY DISCOUNTS EXTENDED TO WHOLESALERS.—Subsection (k)(1) of such section is amended—

(A) by striking ''The term'' and inserting the following:

''(A) IN GENERAL.—Subject to subparagraph (B), the term'';

(B) by striking '', after deducting customary prompt pay discounts''; and

(C) by adding at the end the following:

''(B) EXCLUSION OF CUSTOMARY PROMPT PAY DISCOUNTS EXTENDED TO WHOLESALERS.—The average manufacturer price for a covered outpatient drug shall be determined without regard to customary prompt pay discounts extended to wholesalers.''.

(2) MANUFACTURER REPORTING OF PROMPT PAY DISCOUNTS.—Subsection (b)(3)(A)(i) of such section is amended by inserting '', customary prompt pay discounts extended to wholesalers,'' after ''(k)(1))''.

(3) REQUIREMENT TO PROMULGATE REGULATION.—

(A) INSPECTOR GENERAL RECOMMENDATIONS.—Not later than June 1, 2006, the Inspector General of the Department of Health and Human Services shall—

(i) review the requirements for, and manner in which, average manufacturer prices are determined under section 1927 of the Social Security Act, as amended by this section; and

(ii) shall submit to the Secretary of Health and Human Services and Congress such recommendations for changes in such

requirements or manner as the Inspector General determines to be appropriate.

(B) DEADLINE FOR PROMULGATION.—Not later than July 1, 2007, the Secretary of Health and Human Services shall promulgate a regulation that clarifies the requirements for, and manner in which, average manufacturer prices are determined under section 1927 of the Social Security Act, taking into consideration the recommendations submitted to the Secretary in accordance with subparagraph (A)(ii).

(d) EXCLUSION OF SALES AT A NOMINAL PRICE FROM DETERMINATION OF BEST PRICE.—

(1) MANUFACTURER REPORTING OF SALES.—Subsection (b)(3)(A)(iii) of such section is amended by inserting before the period at the end the following: ", and, for calendar quarters beginning on or after January 1, 2007 and only with respect to the information described in subclause (III), for covered outpatient drugs".

(2) LIMITATION ON SALES AT A NOMINAL PRICE.—Subsection (c)(1) of such section is amended by adding at the end the following new subparagraph:

"(D) LIMITATION ON SALES AT A NOMINAL PRICE.—

"(i) IN GENERAL.—For purposes of subparagraph (C)(ii)(III) and subsection (b)(3)(A)(iii)(III), only sales by a manufacturer of covered outpatient drugs at nominal prices to the following shall be considered to be sales at a nominal price or merely nominal in amount:

"(I) A covered entity described in section 340B(a)(4) of the Public Health Service Act.

"(II) An intermediate care facility for the mentally retarded.

"(III) A State-owned or operated nursing facility.

"(IV) Any other facility or entity that the Secretary determines is a safety net provider to which sales of such drugs at a nominal price would be appropriate based on the factors described in clause (ii).

"(ii) FACTORS.—The factors described in this clause with respect to a facility or entity are the following:

''(I) The type of facility or entity.

''(II) The services provided by the facility or entity.

''(III) The patient population served by the facility or entity.

''(IV) The number of other facilities or entities eligible to purchase at nominal prices in the same service area.

''(iii) NONAPPLICATION.—Clause (i) shall not apply with respect to sales by a manufacturer at a nominal price of covered outpatient drugs pursuant to a master agreement under section 8126 of title 38, United States Code.''.

(e) RETAIL SURVEY PRICES; STATE PAYMENT AND UTILIZATION RATES; AND PERFORMANCE RANKINGS.—Such section is further amended by inserting after subsection (e) the following new subsection:

''(f) SURVEY OF RETAIL PRICES; STATE PAYMENT AND UTILIZATION RATES; AND PERFORMANCE RANKINGS.—

''(1) SURVEY OF RETAIL PRICES.—

''(A) USE OF VENDOR.—The Secretary may contract services for—

"(i) the determination on a monthly basis of retail survey prices for covered outpatient drugs that represent a nationwide average of consumer purchase prices for such drugs, net of all discounts and rebates (to the extent any information with respect to such discounts and rebates is available); and

"(ii) the notification of the Secretary when a drug product that is therapeutically and pharmaceutically equivalent and bioequivalent becomes generally available.

"(B) SECRETARY RESPONSE TO NOTIFICATION OF AVAILABILITY OF MULTIPLE SOURCE PRODUCTS.—If contractor notifies the Secretary under subparagraph (A)(ii) that a drug product described in such subparagraph has become generally available, the Secretary shall make a determination, within 7 days after receiving such notification, as to whether the product is now described in subsection (e)(4).

"(C) USE OF COMPETITIVE BIDDING.—In contracting for such services, the Secretary shall competitively bid for an outside vendor that has a demonstrated history in—

"(i) surveying and determining, on a representative nationwide basis, retail prices for ingredient costs of prescription drugs;

"(ii) working with retail pharmacies, commercial payers, and States in obtaining and disseminating such price information; and

"(iii) collecting and reporting such price information on at least a monthly basis.

In contracting for such services, the Secretary may waive such provisions of the Federal Acquisition Regulation as are necessary for the efficient implementation of this subsection, other than provisions relating to confidentiality of information and such other provisions as the Secretary determines appropriate.

"(D) ADDITIONAL PROVISIONS.—A contract with a vendor under this paragraph shall include such terms and conditions as the Secretary shall specify, including the following:

"(i) The vendor must monitor the marketplace and report to the Secretary

each time there is a new covered outpatient drug generally available.

''(ii) The vendor must update the Secretary no less often than monthly on the retail survey prices for covered outpatient drugs.

''(iii) The contract shall be effective for a term of 2 years.

''(E) AVAILABILITY OF INFORMATION TO STATES.—Information on retail survey prices obtained under this paragraph, including applicable information on single source drugs, shall be provided to States on at least a monthly basis. The Secretary shall devise and implement a means for providing access to each State agency designated under section 1902(a)(5) with responsibility for the administration or supervision of the administration of the State plan under this title of the retail survey price determined under this paragraph.

''(2) ANNUAL STATE REPORT.—Each State shall annually report to the Secretary information on—

''(A) the payment rates under the State plan under this title for covered outpatient drugs;

''(B) the dispensing fees paid under such plan for such drugs; and

''(C) utilization rates for noninnovator multiple source drugs under such plan.

''(3) ANNUAL STATE PERFORMANCE RANKINGS.—

''(A) COMPARATIVE ANALYSIS.—The Secretary annually shall compare, for the 50 most widely prescribed drugs identified by the Secretary, the national retail sales price data (collected under paragraph (1)) for such drugs with data on prices under this title for each such drug for each State.

''(B) AVAILABILITY OF INFORMATION.—The Secretary shall submit to Congress and the States full information regarding the annual rankings made under subparagraph (A).

''(4) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary of Health and Human Services $5,000,000 for each of fiscal years 2006 through 2010 to carry out this subsection.''.

(f) MISCELLANEOUS AMENDMENTS.—

(1) IN GENERAL.—Sections 1927(g)(1)(B)(i)(II) and 1861(t)(2)(B)(ii)(I) of such Act are each amended by inserting ''(or its successor publications)'' after ''United States Pharmacopoeia-Drug Information''.

(2) PAPERWORK REDUCTION.—The last sentence of section 1927(g)(2)(A)(ii) of such Act (42 U.S.C. 1396r–8(g)(2)(A)(ii)) is amended by inserting before the period at the end the following: '', or to require verification of the offer to provide consultation or a refusal of such offer''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on the date of the enactment of this Act.

(g) EFFECTIVE DATE.—Except as otherwise provided, the amendments made by this section shall take effect on January 1, 2007, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

SEC. 6002. COLLECTION AND SUBMISSION OF UTILIZATION DATA FOR CERTAIN PHYSICIAN ADMINISTERED DRUGS.

(a) IN GENERAL.—Section 1927(a) of the Social Security Act (42 U.S.C. 1396r–8(a)) is amended by adding at the end the following new paragraph:

''(7) REQUIREMENT FOR SUBMISSION OF UTILIZATION DATA FOR CERTAIN PHYSICIAN ADMINISTERED DRUGS.—

''(A) SINGLE SOURCE DRUGS.—In order for payment to be available under section 1903(a) for a covered outpatient drug that is a single source drug that is physician administered under this title (as determined by the Secretary), and that is administered on or after January 1, 2006, the State shall provide for the collection and submission of such utilization data and coding (such as J-codes and National Drug Code numbers) for each such drug as the Secretary may specify as necessary to identify the manufacturer of the drug in order to secure rebates under this section for drugs administered for which payment is made under this title.

''(B) MULTIPLE SOURCE DRUGS.—

''(i) IDENTIFICATION OF MOST FREQUENTLY PHYSICIAN ADMINISTERED MULTIPLE SOURCE DRUGS.—Not later than January 1, 2007, the Secretary shall publish a list of the 20 physician administered multiple source drugs that the Secretary determines have the highest dollar volume of physician administered drugs dispensed under this title. The Secretary may modify such list from year to year to reflect changes in such volume.

''(ii) REQUIREMENT.—In order for payment to be available under section 1903(a) for a covered outpatient drug that is a multiple source drug that is physician administered (as determined by the Secretary), that is on the list published under clause (i), and that is administered on or after January 1, 2008, the State shall provide for the submission of such utilization data and coding (such as J-codes and National Drug Code numbers) for each such drug as the Secretary may specify as necessary to identify the manufacturer of the

drug in order to secure rebates under this section.

''(C) USE OF NDC CODES.—Not later than January 1, 2007, the information shall be submitted under subparagraphs (A) and (B)(ii) using National Drug Code codes unless the Secretary specifies that an alternative coding system should be used.

''(D) HARDSHIP WAIVER.—The Secretary may delay the application of subparagraph (A) or (B)(ii), or both, in the case of a State to prevent hardship to States which require additional time to implement the reporting system required under the respective subparagraph.''.

(b) LIMITATION ON PAYMENT.—Section 1903(i)(10) of such Act (42 U.S.C. 1396b(i)(10)), is amended—

(1) by striking ''and'' at the end of subparagraph (A);

(2) by striking ''or'' at the end of subparagraph (B) and inserting ''and''; and

(3) by adding at the end the following new subparagraph:

''(C) with respect to covered outpatient drugs described in section 1927(a)(7), unless information respecting utilization data and coding on such drugs

that is required to be submitted under such section is submitted in accordance with such section; or''.

SEC. 6003. IMPROVED REGULATION OF DRUGS SOLD UNDER A NEW DRUG APPLICATION APPROVED UNDER SECTION 505(c) OF THE FEDERAL FOOD, DRUG, AND COSMETIC ACT.

(a) INCLUSION WITH OTHER REPORTED AVERAGE MANUFACTURER AND BEST PRICES.—Section 1927(b)(3)(A) of the Social Security Act (42 U.S.C. 1396r–8(b)(3)(A)) is amended—

(1) by striking clause (i) and inserting the following:

''(i) not later than 30 days after the last day of each rebate period under the agreement—

''(I) on the average manufacturer price (as defined in subsection (k)(1)) for covered outpatient drugs for the rebate period under the agreement (including for all such drugs that are sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act); and

''(II) for single source drugs and innovator multiple source drugs (including all such drugs that are sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act), on the manufacturer's best price (as defined in subsection (c)(1)(C)) for such drugs for the rebate period under the agreement;''; and

(2) in clause (ii), by inserting ''(including for such drugs that are sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act)'' after ''drugs''.

(b) CONFORMING AMENDMENTS.—Section 1927 of such Act (42 U.S.C. 1396r–8) is amended—

(1) in subsection (c)(1)(C)—

(A) in clause (i), in the matter preceding subclause (I), by inserting after ''or innovator multiple source drug of a manufacturer'' the following: ''(including the lowest price available to any entity for any such drug of a manufacturer that is sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act)''; and

(B) in clause (ii)—

(i) in subclause (II), by striking ''and'' at the end;

(ii) in subclause (III), by striking the period at the end and inserting ''; and''; and

(iii) by adding at the end the following:

''(IV) in the case of a manufacturer that approves, allows, or otherwise permits any other drug of the manufacturer to be sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act, shall be inclusive of the lowest price for such authorized drug available from the manufacturer during the rebate period to any manufacturer, wholesaler, retailer, provider, health maintenance organization, nonprofit entity, or governmental entity within the United States, excluding those prices described in subclauses (I) through (IV) of clause (i).''; and

(2) in subsection (k), as amended by section 6001(c)(1), by adding at the end the following:

"(C) INCLUSION OF SECTION 505(c) DRUGS.—In the case of a manufacturer that approves, allows, or otherwise permits any drug of the manufacturer to be sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act, such term shall be inclusive of the average price paid for such drug by wholesalers for drugs distributed to the retail pharmacy class of trade.".

(c) EFFECTIVE DATE.—The amendments made by this section take effect on January 1, 2007.

SEC. 6004. CHILDREN'S HOSPITAL PARTICIPATION IN SECTION 340B DRUG DISCOUNT PROGRAM.

(a) IN GENERAL.—Section 1927(a)(5)(B) of the Social Security Act (42 U.S.C. 1396r–8(a)(5)(B)) is amended by inserting before the period at the end the following: "and a children's hospital described in section 1886(d)(1)(B)(iii) which meets the requirements of clauses (i) and (iii) of section 340B(b)(4)(L) of the Public Health Service Act and which would meet the requirements of clause (ii) of such section if that clause were applied by taking into account the percentage of care pro-

vided by the hospital to patients eligible for medical assistance under a State plan under this title''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to drugs purchased on or after the date of the enactment of this Act.

CHAPTER 2—LONG-TERM CARE UNDER MEDICAID

Subchapter A—Reform of Asset Transfer Rules

SEC. 6011. LENGTHENING LOOK-BACK PERIOD; CHANGE IN BEGINNING DATE FOR PERIOD OF INELIGIBILITY.

(a) LENGTHENING LOOK-BACK PERIOD FOR ALL DISPOSALS TO 5 YEARS.—Section 1917(c)(1)(B)(i) of the Social Security Act (42 U.S.C. 1396p(c)(1)(B)(i)) is amended by inserting ''or in the case of any other disposal of assets made on or after the date of the enactment of the Deficit Reduction Act of 2005'' before '', 60 months''.

(b) CHANGE IN BEGINNING DATE FOR PERIOD OF INELIGIBILITY.—Section 1917(c)(1)(D) of such Act (42 U.S.C. 1396p(c)(1)(D)) is amended—

(1) by striking ''(D) The date'' and inserting ''(D)(i) In the case of a transfer of asset made before the date of the enactment of the Deficit Reduction Act of 2005, the date''; and

(2) by adding at the end the following new clause:

''(ii) In the case of a transfer of asset made on or after the date of the enactment of the Deficit Reduction Act of 2005, the date specified in this subparagraph is the first day of a month during or after which assets have been transferred for less than fair market value, or the date on which the individual is eligible for medical assistance under the State plan and would otherwise be receiving institutional level care described in subparagraph (C) based on an approved application for such care but for the application of the penalty period, whichever is later, and which does not occur during any other period of ineligibility under this subsection.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to transfers made on or after the date of the enactment of this Act.

(d) AVAILABILITY OF HARDSHIP WAIVERS.—Each State shall provide for a hardship waiver process in accordance with section 1917(c)(2)(D) of the Social Security Act (42 U.S.C. 1396p(c)(2)(D))—

(1) under which an undue hardship exists when application of the transfer of assets provision would deprive the individual—

(A) of medical care such that the individual's health or life would be endangered; or

(B) of food, clothing, shelter, or other necessities of life; and

(2) which provides for—

(A) notice to recipients that an undue hardship exception exists;

(B) a timely process for determining whether an undue hardship waiver will be granted; and

(C) a process under which an adverse determination can be appealed.

(e) ADDITIONAL PROVISIONS ON HARDSHIP WAIVERS.—

(1) APPLICATION BY FACILITY.—Section 1917(c)(2) of the Social Security Act (42 U.S.C. 1396p(c)(2)) is amended—

(A) by striking the semicolon at the end of subparagraph (D) and inserting a period; and

(B) by adding after and below such subparagraph the following:

''The procedures established under subparagraph (D) shall permit the facility in which the institutionalized individual is residing to file an undue hardship waiver application on behalf of the indi-

vidual with the consent of the individual or the personal representative of the individual.''.

(2) AUTHORITY TO MAKE BED HOLD PAYMENTS FOR HARDSHIP APPLICANTS.—Such section is further amended by adding at the end the following: ''While an application for an undue hardship waiver is pending under subparagraph (D) in the case of an individual who is a resident of a nursing facility, if the application meets such criteria as the Secretary specifies, the State may provide for payments for nursing facility services in order to hold the bed for the individual at the facility, but not in excess of payments for 30 days.''.

SEC. 6012. DISCLOSURE AND TREATMENT OF ANNUITIES.

(a) IN GENERAL.—Section 1917 of the Social Security Act (42 U.S.C. 1396p) is amended by redesignating subsection (e) as subsection (f) and by inserting after subsection (d) the following new subsection:

''(e)(1) In order to meet the requirements of this section for purposes of section 1902(a)(18), a State shall require, as a condition for the provision of medical assistance for services described in subsection (c)(1)(C)(i) (relating to long-term care services) for an individual, the application of the individual for such assistance (including any recertification of eligibility for such assistance) shall

disclose a description of any interest the individual or community spouse has in an annuity (or similar financial instrument, as may be specified by the Secretary), regardless of whether the annuity is irrevocable or is treated as an asset. Such application or recertification form shall include a statement that under paragraph (2) the State becomes a remainder beneficiary under such an annuity or similar financial instrument by virtue of the provision of such medical assistance.

''(2)(A) In the case of disclosure concerning an annuity under subsection (c)(1)(F), the State shall notify the issuer of the annuity of the right of the State under such subsection as a preferred remainder beneficiary in the annuity for medical assistance furnished to the individual. Nothing in this paragraph shall be construed as preventing such an issuer from notifying persons with any other remainder interest of the State's remainder interest under such subsection.

''(B) In the case of such an issuer receiving notice under subparagraph (A), the State may require the issuer to notify the State when there is a change in the amount of income or principal being withdrawn from the amount that was being withdrawn at the time of the most recent disclosure described in paragraph (1). A State shall take such information into account in determining the amount

of the State's obligations for medical assistance or in the individual's eligibility for such assistance.

''(3) The Secretary may provide guidance to States on categories of transactions that may be treated as a transfer of asset for less than fair market value.

''(4) Nothing in this subsection shall be construed as preventing a State from denying eligibility for medical assistance for an individual based on the income or resources derived from an annuity described in paragraph (1).''.

(b) REQUIREMENT FOR STATE TO BE NAMED AS A REMAINDER BENEFICIARY.—Section 1917(c)(1) of such Act (42 U.S.C. 1396p(c)(1)), is amended by adding at the end the following:

''(F) For purposes of this paragraph, the purchase of an annuity shall be treated as the disposal of an asset for less than fair market value unless—

''(i) the State is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant under this title; or

''(ii) the State is named as such a beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such

child disposes of any such remainder for less than fair market value.''.

(c) INCLUSION OF TRANSFERS TO PURCHASE BALLOON ANNUITIES.—Section 1917(c)(1) of such Act (42 U.S.C. 1396p(c)(1)), as amended by subsection (b), is amended by adding at the end the following:

''(G) For purposes of this paragraph with respect to a transfer of assets, the term 'assets' includes an annuity purchased by or on behalf of an annuitant who has applied for medical assistance with respect to nursing facility services or other long-term care services under this title unless—

''(i) the annuity is—

''(I) an annuity described in subsection (b) or (q) of section 408 of the Internal Revenue Code of 1986; or

''(II) purchased with proceeds from—

''(aa) an account or trust described in subsection (a), (c), (p) of section 408 of such Code;

''(bb) a simplified employee pension (within the meaning of section 408(k) of such Code); or

''(cc) a Roth IRA described in section 408A of such Code; or

''(ii) the annuity—

''(I) is irrevocable and nonassignable;

''(II) is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration); and

''(III) provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to transactions (including the purchase of an annuity) occurring on or after the date of the enactment of this Act.

SEC. 6013. APPLICATION OF "INCOME-FIRST" RULE IN APPLYING COMMUNITY SPOUSE'S INCOME BEFORE ASSETS IN PROVIDING SUPPORT OF COMMUNITY SPOUSE.

(a) IN GENERAL.—Section 1924(d) of the Social Security Act (42 U.S.C. 1396r–5(d)) is amended by adding at the end the following new subparagraph:

''(6) APPLICATION OF 'INCOME FIRST' RULE TO REVISION OF COMMUNITY SPOUSE RESOURCE ALLOWANCE.—For purposes of this subsection and subsections (c) and (e), a State must consider that all income of the institutionalized spouse that could

be made available to a community spouse, in accordance with the calculation of the community spouse monthly income allowance under this subsection, has been made available before the State allocates to the community spouse an amount of resources adequate to provide the difference between the minimum monthly maintenance needs allowance and all income available to the community spouse.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to transfers and allocations made on or after the date of the enactment of this Act by individuals who become institutionalized spouses on or after such date.

SEC. 6014. DISQUALIFICATION FOR LONG-TERM CARE ASSISTANCE FOR INDIVIDUALS WITH SUBSTANTIAL HOME EQUITY.

(a) IN GENERAL.—Section 1917 of the Social Security Act, as amended by section 6012(a), is further amended by redesignating subsection (f) as subsection (g) and by inserting after subsection (e) the following new subsection:

''(f)(1)(A) Notwithstanding any other provision of this title, subject to subparagraphs (B) and (C) of this paragraph and paragraph (2), in determining eligibility of an individual for medical assistance with respect to nurs-

ing facility services or other long-term care services, the individual shall not be eligible for such assistance if the individual's equity interest in the individual's home exceeds $500,000.

''(B) A State may elect, without regard to the requirements of section 1902(a)(1) (relating to statewideness) and section 1902(a)(10)(B) (relating to comparability), to apply subparagraph (A) by substituting for '$500,000', an amount that exceeds such amount, but does not exceed $750,000.

''(C) The dollar amounts specified in this paragraph shall be increased, beginning with 2011, from year to year based on the percentage increase in the consumer price index for all urban consumers (all items; United States city average), rounded to the nearest $1,000.

''(2) Paragraph (1) shall not apply with respect to an individual if—

''(A) the spouse of such individual, or

''(B) such individual's child who is under age 21, or (with respect to States eligible to participate in the State program established under title XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1614,

is lawfully residing in the individual's home.

''(3) Nothing in this subsection shall be construed as preventing an individual from using a reverse mortgage or home equity loan to reduce the individual's total equity interest in the home.

''(4) The Secretary shall establish a process whereby paragraph (1) is waived in the case of a demonstrated hardship.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to individuals who are determined eligible for medical assistance with respect to nursing facility services or other long-term care services based on an application filed on or after January 1, 2006.

SEC. 6015. ENFORCEABILITY OF CONTINUING CARE RETIREMENT COMMUNITIES (CCRC) AND LIFE CARE COMMUNITY ADMISSION CONTRACTS.

(a) ADMISSION POLICIES OF NURSING FACILITIES.—Section 1919(c)(5) of the Social Security Act (42 U.S.C. 1396r(c)(5)) is amended—

(1) in subparagraph (A)(i)(II), by inserting ''subject to clause (v),'' after ''(II)''; and

(2) by adding at the end of subparagraph (B) the following new clause:

''(v) TREATMENT OF CONTINUING CARE RETIREMENT COMMUNITIES ADMIS-

SION CONTRACTS.—Notwithstanding subclause (II) of subparagraph (A)(i), subject to subsections (c) and (d) of section 1924, contracts for admission to a State licensed, registered, certified, or equivalent continuing care retirement community or life care community, including services in a nursing facility that is part of such community, may require residents to spend on their care resources declared for the purposes of admission before applying for medical assistance.''.

(b) TREATMENT OF ENTRANCE FEES.—Section 1917 of such Act (42 U.S.C. 1396p), as amended by sections 6012(a) and 6014(a), is amended by redesignating subsection (g) as subsection (h) and by inserting after subsection (f) the following new subsection:

''(g) TREATMENT OF ENTRANCE FEES OF INDIVIDUALS RESIDING IN CONTINUING CARE RETIREMENT COMMUNITIES.—

''(1) IN GENERAL.—For purposes of determining an individual's eligibility for, or amount of, benefits under a State plan under this title, the rules specified in paragraph (2) shall apply to individuals residing in continuing care retirement communities

or life care communities that collect an entrance fee on admission from such individuals.

''(2) TREATMENT OF ENTRANCE FEE.—For purposes of this subsection, an individual's entrance fee in a continuing care retirement community or life care community shall be considered a resource available to the individual to the extent that—

''(A) the individual has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care should other resources or income of the individual be insufficient to pay for such care;

''(B) the individual is eligible for a refund of any remaining entrance fee when the individual dies or terminates the continuing care retirement community or life care community contract and leaves the community; and

''(C) the entrance fee does not confer an ownership interest in the continuing care retirement community or life care community.''.

SEC. 6016. ADDITIONAL REFORMS OF MEDICAID ASSET TRANSFER RULES.

(a) REQUIREMENT TO IMPOSE PARTIAL MONTHS OF INELIGIBILITY.—Section 1917(c)(1)(E) of the Social Se-

curity Act (42 U.S.C. 1396p(c)(1)(E)) is amended by adding at the end the following:

''(iv) A State shall not round down, or otherwise disregard any fractional period of ineligibility determined under clause (i) or (ii) with respect to the disposal of assets.''.

(b) AUTHORITY FOR STATES TO ACCUMULATE MULTIPLE TRANSFERS INTO ONE PENALTY PERIOD.—Section 1917(c)(1) of such Act (42 U.S.C. 1396p(c)(1)), as amended by subsections (b) and (c) of section 6012, is amended by adding at the end the following:

''(H) Notwithstanding the preceding provisions of this paragraph, in the case of an individual (or individual's spouse) who makes multiple fractional transfers of assets in more than 1 month for less than fair market value on or after the applicable look-back date specified in subparagraph (B), a State may determine the period of ineligibility applicable to such individual under this paragraph by—

''(i) treating the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) during all months on or after the look-back date specified in subparagraph (B) as 1 transfer for purposes of clause (i) or (ii) (as the case may be) of subparagraph (E); and

''(ii) beginning such period on the earliest date which would apply under subparagraph (D) to any of such transfers.''.

(c) INCLUSION OF TRANSFER OF CERTAIN NOTES AND LOANS ASSETS.—Section 1917(c)(1) of such Act (42 U.S.C. 1396 p(c)(1)), as amended by subsection (b), is amended by adding at the end the following:

''(I) For purposes of this paragraph with respect to a transfer of assets, the term 'assets' includes funds used to purchase a promissory note, loan, or mortgage unless such note, loan, or mortgage—

''(i) has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration);

''(ii) provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and

''(iii) prohibits the cancellation of the balance upon the death of the lender.

In the case of a promissory note, loan, or mortgage that does not satisfy the requirements of clauses (i) through (iii), the value of such note, loan, or mortgage shall be the outstanding balance due as of the date of the individ-

ual's application for medical assistance for services described in subparagraph (C).''.

(d) INCLUSION OF TRANSFERS TO PURCHASE LIFE ESTATES.—Section 1917(c)(1) of such Act (42 U.S.C. 1396p(c)(1)), as amended by subsection (c), is amended by adding at the end the following:

''(J) For purposes of this paragraph with respect to a transfer of assets, the term 'assets' includes the purchase of a life estate interest in another individual's home unless the purchaser resides in the home for a period of at least 1 year after the date of the purchase.''.

(e) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the amendments made by this section shall apply to payments under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) for calendar quarters beginning on or after the date of enactment of this Act, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(2) EXCEPTIONS.—The amendments made by this section shall not apply—

(A) to medical assistance provided for services furnished before the date of enactment;

(B) with respect to assets disposed of on or before the date of enactment of this Act; or

(C) with respect to trusts established on or before the date of enactment of this Act.

(3) EXTENSION OF EFFECTIVE DATE FOR STATE LAW AMENDMENT.—In the case of a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by a provision of this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session is considered to be a separate regular session of the State legislature.

Subchapter B—Expanded Access to Certain Benefits

SEC. 6021. EXPANSION OF STATE LONG-TERM CARE PARTNERSHIP PROGRAM.

(a) EXPANSION AUTHORITY.—

(1) IN GENERAL.—Section 1917(b) of the Social Security Act (42 U.S.C. 1396p(b)) is amended—

(A) in paragraph (1)(C)—

(i) in clause (ii), by inserting ''and which satisfies clause (iv), or which has a State plan amendment that provides for a qualified State long-term care insurance partnership (as defined in clause (iii))'' after ''1993,''; and

(ii) by adding at the end the following new clauses:

''(iii) For purposes of this paragraph, the term 'qualified State long-term care insurance partnership' means an approved State plan amendment under this title that provides for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a

long-term care insurance policy if the following requirements are met:

"(I) The policy covers an insured who was a resident of such State when coverage first became effective under the policy.

"(II) The policy is a qualified long-term care insurance policy (as defined in section 7702B(b) of the Internal Revenue Code of 1986) issued not earlier than the effective date of the State plan amendment.

"(III) The policy meets the model regulations and the requirements of the model Act specified in paragraph (5).

"(IV) If the policy is sold to an individual who—

"(aa) has not attained age 61 as of the date of purchase, the policy provides compound annual inflation protection;

"(bb) has attained age 61 but has not attained age 76 as of such date, the policy provides some level of inflation protection; and

"(cc) has attained age 76 as of such date, the policy may (but is not required

to) provide some level of inflation protection.

''(V) The State Medicaid agency under section 1902(a)(5) provides information and technical assistance to the State insurance department on the insurance department's role of assuring that any individual who sells a long-term care insurance policy under the partnership receives training and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care.

''(VI) The issuer of the policy provides regular reports to the Secretary, in accordance with regulations of the Secretary, that include notification regarding when benefits provided under the policy have been paid and the amount of such benefits paid, notification regarding when the policy otherwise terminates, and such other information as the Secretary determines may be appropriate to the administration of such partnerships.

''(VII) The State does not impose any requirement affecting the terms or benefits of such a policy unless the State imposes such re-

quirement on long-term care insurance policies without regard to whether the policy is covered under the partnership or is offered in connection with such a partnership.

In the case of a long-term care insurance policy which is exchanged for another such policy, subclause (I) shall be applied based on the coverage of the first such policy that was exchanged. For purposes of this clause and paragraph (5), the term 'long-term care insurance policy' includes a certificate issued under a group insurance contract

''(iv) With respect to a State which had a State plan amendment approved as of May 14, 1993, such a State satisfies this clause for purposes of clause (ii) if the Secretary determines that the State plan amendment provides for consumer protection standards which are no less stringent than the consumer protection standards which applied under such State plan amendment as of December 31, 2005.

''(v) The regulations of the Secretary required under clause (iii)(VI) shall be promulgated after consultation with the National Association of Insurance Commissioners, issuers of long-term care insurance policies, States with experience with long-term care insurance partnership plans, other States, and

representatives of consumers of long-term care insurance policies, and shall specify the type and format of the data and information to be reported and the frequency with which such reports are to be made. The Secretary, as appropriate, shall provide copies of the reports provided in accordance with that clause to the State involved.

''(vi) The Secretary, in consultation with other appropriate Federal agencies, issuers of long-term care insurance, the National Association of Insurance Commissioners, State insurance commissioners, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, shall develop recommendations for Congress to authorize and fund a uniform minimum data set to be reported electronically by all issuers of long-term care insurance policies under qualified State long-term care insurance partnerships to a secure, centralized electronic query and report-generating mechanism that the State, the Secretary, and other Federal agencies can access.''; and

(B) by adding at the end the following:

''(5)(A) For purposes of clause (iii)(III), the model regulations and the requirements of the model Act specified in this paragraph are:

''(i) In the case of the model regulation, the following requirements:

''(I) Section 6A (relating to guaranteed renewal or noncancellability), other than paragraph (5) thereof, and the requirements of section 6B of the model Act relating to such section 6A.

''(II) Section 6B (relating to prohibitions on limitations and exclusions) other than paragraph (7) thereof.

''(III) Section 6C (relating to extension of benefits).

''(IV) Section 6D (relating to continuation or conversion of coverage).

''(V) Section 6E (relating to discontinuance and replacement of policies).

''(VI) Section 7 (relating to unintentional lapse).

''(VII) Section 8 (relating to disclosure), other than sections 8F, 8G, 8H, and 8I thereof.

''(VIII) Section 9 (relating to required disclosure of rating practices to consumer).

"(IX) Section 11 (relating to prohibitions against post-claims underwriting).

"(X) Section 12 (relating to minimum standards).

"(XI) Section 14 (relating to application forms and replacement coverage).

"(XII) Section 15 (relating to reporting requirements).

"(XIII) Section 22 (relating to filing requirements for marketing).

"(XIV) Section 23 (relating to standards for marketing), including inaccurate completion of medical histories, other than paragraphs (1), (6), and (9) of section 23C.

"(XV) Section 24 (relating to suitability).

"(XVI) Section 25 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).

"(XVII) The provisions of section 26 relating to contingent nonforfeiture benefits, if the policyholder declines the offer of a nonforfeiture provision described in paragraph (4).

"(XVIII) Section 29 (relating to standard format outline of coverage).

"(XIX) Section 30 (relating to requirement to deliver shopper's guide).

"(ii) In the case of the model Act, the following:

"(I) Section 6C (relating to preexisting conditions).

"(II) Section 6D (relating to prior hospitalization).

"(III) The provisions of section 8 relating to contingent nonforfeiture benefits.

"(IV) Section 6F (relating to right to return).

"(V) Section 6G (relating to outline of coverage).

"(VI) Section 6H (relating to requirements for certificates under group plans).

"(VII) Section 6J (relating to policy summary).

"(VIII) Section 6K (relating to monthly reports on accelerated death benefits).

"(IX) Section 7 (relating to incontestability period).

"(B) For purposes of this paragraph and paragraph (1)(C)—

"(i) the terms 'model regulation' and 'model Act' mean the long-term care insurance model regu-

lation, and the long-term care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000);

''(ii) any provision of the model regulation or model Act listed under subparagraph (A) shall be treated as including any other provision of such regulation or Act necessary to implement the provision; and

''(iii) with respect to a long-term care insurance policy issued in a State, the policy shall be deemed to meet applicable requirements of the model regulation or the model Act if the State plan amendment under paragraph (1)(C)(iii) provides that the State insurance commissioner for the State certifies (in a manner satisfactory to the Secretary) that the policy meets such requirements.

''(C) Not later than 12 months after the National Association of Insurance Commissioners issues a revision, update, or other modification of a model regulation or model Act provision specified in subparagraph (A), or of any provision of such regulation or Act that is substantively related to a provision specified in such subparagraph, the Secretary shall review the changes made to the provision, determine whether incorporating such changes

into the corresponding provision specified in such subparagraph would improve qualified State long-term care insurance partnerships, and if so, shall incorporate the changes into such provision.''.

(2) STATE REPORTING REQUIREMENTS.—Nothing in clauses (iii)(VI) and (v) of section 1917(b)(1)(C) of the Social Security Act (as added by paragraph (1)) shall be construed as prohibiting a State from requiring an issuer of a long-term care insurance policy sold in the State (regardless of whether the policy is issued under a qualified State long-term care insurance partnership under section 1917(b)(1)(C)(iii) of such Act) to require the issuer to report information or data to the State that is in addition to the information or data required under such clauses.

(3) EFFECTIVE DATE.—A State plan amendment that provides for a qualified State long-term care insurance partnership under the amendments made by paragraph (1) may provide that such amendment is effective for long-term care insurance policies issued on or after a date, specified in the amendment, that is not earlier than the first day of the first calendar quarter in which the plan amend-

ment was submitted to the Secretary of Health and Human Services.

(b) STANDARDS FOR RECIPROCAL RECOGNITION AMONG PARTNERSHIP STATES.—In order to permit portability in long-term care insurance policies purchased under State long-term care insurance partnerships, the Secretary of Health and Human Services shall develop, not later than January 1, 2007, and in consultation with the National Association of Insurance Commissioners, issuers of long-term care insurance policies, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, standards for uniform reciprocal recognition of such policies among States with qualified State long-term care insurance partnerships under which—

(1) benefits paid under such policies will be treated the same by all such States; and

(2) States with such partnerships shall be subject to such standards unless the State notifies the Secretary in writing of the State's election to be exempt from such standards.

(c) ANNUAL REPORTS TO CONGRESS.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall annually report to Congress

on the long-term care insurance partnerships established in accordance with section 1917(b)(1)(C)(ii) of the Social Security Act (42 U.S.C. 1396p(b)(1)(C)(ii)) (as amended by subsection (a)(1)). Such reports shall include analyses of the extent to which such partnerships expand or limit access of individuals to long-term care and the impact of such partnerships on Federal and State expenditures under the Medicare and Medicaid programs. Nothing in this section shall be construed as requiring the Secretary to conduct an independent review of each long-term care insurance policy offered under or in connection with such a partnership.

(2) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary of Health and Human Services, $1,000,000 for the period of fiscal years 2006 through 2010 to carry out paragraph (1).

(d) NATIONAL CLEARINGHOUSE FOR LONG-TERM CARE INFORMATION.—

(1) ESTABLISHMENT.—The Secretary of Health and Human Services shall establish a National Clearinghouse for Long-Term Care Information. The

Clearinghouse may be established through a contract or interagency agreement.

(2) DUTIES.—

(A) IN GENERAL.—The National Clearinghouse for Long-Term Care Information shall—

(i) educate consumers with respect to the availability and limitations of coverage for long-term care under the Medicaid program and provide contact information for obtaining State-specific information on long-term care coverage, including eligibility and estate recovery requirements under State Medicaid programs;

(ii) provide objective information to assist consumers with the decisionmaking process for determining whether to purchase long-term care insurance or to pursue other private market alternatives for purchasing long-term care and provide contact information for additional objective resources on planning for long-term care needs; and

(iii) maintain a list of States with State long-term care insurance partnerships under the Medicaid program that

provide reciprocal recognition of long-term care insurance policies issued under such partnerships.

(B) REQUIREMENT.—In providing information to consumers on long-term care in accordance with this subsection, the National Clearinghouse for Long-Term Care Information shall not advocate in favor of a specific long-term care insurance provider or a specific long-term care insurance policy.

(3) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to carry out this subsection, $3,000,000 for each of fiscal years 2006 through 2010.

CHAPTER 3—ELIMINATING FRAUD, WASTE, AND ABUSE IN MEDICAID

SEC. 6031. LIMITATION ON USE OF CONTINGENCY FEE ARRANGEMENTS.

(a) IN GENERAL.—Section 1903(i) of the Social Security Act (42 U.S.C. 1396b(i)), as amended by section 104(b) of Public Law 109–91, is amended—

(1) in paragraph (20), by adding ''or'' at the end;

(2) by striking the period at the end of paragraph (21) and inserting ''; or''; and

(3) by inserting after paragraph (21), the following:

''(22) with respect to any amount expended in connection with a contract or agreement (other than a risk contract under section 1903(m)) between the State agency under section 1902(a)(5) (or any State or local agency designated by such agency to administer any portion of the State plan under this title) and a consultant or other contractor if the terms of compensation for the consultant or other contractor do not meet the standards established by the Secretary of Health and Human Services under section 6031(b) of the Deficit Reduction Act of 2005.''.

(b) CONTINGENCY FEE ARRANGEMENT STANDARDS.—Not later than 6 months after the date of enactment of this Act, the Secretary of Health and Human Services shall issue standards for the terms of compensation of consultants and other individuals or entities contracting with State agencies (or their designees) administering State Medicaid plans under title XIX of the Social Security Act that ensure prudent purchasing and program integrity with respect to Federal funds. The Secretary of Health and Human Services shall review and revise, as necessary, such standards to promptly address new com-

pensation arrangements that may present a risk to program integrity under such title.

(c) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary of Health and Human Services, $550,000 for fiscal year 2006 to carry out the amendment made by subsection (a) and subsection (b).

(d) EFFECTIVE DATE.—Except as provided in section 6035(e), the amendments made by subsection (a) take effect on January 1, 2007.

SEC. 6032. ENCOURAGING THE ENACTMENT OF STATE FALSE CLAIMS ACTS.

(a) IN GENERAL.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by inserting after section 1908A the following:

''STATE FALSE CLAIMS ACT REQUIREMENTS FOR INCREASED STATE SHARE OF RECOVERIES

''SEC. 1909. (a) IN GENERAL.—Notwithstanding section 1905(b), if a State has in effect a law relating to false or fraudulent claims that meets the requirements of subsection (b), the Federal medical assistance percentage with respect to any amounts recovered under a State action brought under such law, shall be decreased by 10 percentage points.

''(b) REQUIREMENTS.—For purposes of subsection (a), the requirements of this subsection are that the In-

spector General of the Department of Health and Human Services, in consultation with the Attorney General, determines that the State has in effect a law that meets the following requirements:

''(1) The law establishes liability to the State for false or fraudulent claims described in section 3729 of title 31, United States Code, with respect to any expenditure described in section 1903(a).

''(2) The law contains provisions that are at least as effective in rewarding and facilitating qui tam actions for false or fraudulent claims as those described in sections 3730 through 3732 of title 31, United States Code.

''(3) The law contains a requirement for filing an action under seal for 60 days with review by the State Attorney General.

''(4) The law contains a civil penalty that is not less than the amount of the civil penalty authorized under section 3729 of title 31, United States Code.

''(c) DEEMED COMPLIANCE.—A State that, as of January 1, 2007, has a law in effect that meets the requirements of subsection (b) shall be deemed to be in compliance with such requirements for so long as the law continues to meet such requirements.

''(d) NO PRECLUSION OF BROADER LAWS.—Nothing in this section shall be construed as prohibiting a State that has in effect a law that establishes liability to the State for false or fraudulent claims described in section 3729 of title 31, United States Code, with respect to programs in addition to the State program under this title, or with respect to expenditures in addition to expenditures described in section 1903(a), from being considered to be in compliance with the requirements of subsection (a) so long as the law meets such requirements.''.

(b) EFFECTIVE DATE.—Except as provided in section 6035(e), the amendments made by this section take effect on January 1, 2007.

SEC. 6033. EMPLOYEE EDUCATION ABOUT FALSE CLAIMS RECOVERY.

(a) IN GENERAL.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(1) in paragraph (66), by striking ''and'' at the end;

(2) in paragraph (67) by striking the period at the end and inserting ''; and''; and

(3) by inserting after paragraph (67) the following:

''(68) provide that any entity that receives or makes annual payments under the State plan of at

least $5,000,000, as a condition of receiving such payments, shall—

''(A) establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, United States Code, administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1128B(f));

''(B) include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and

''(C) include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of employees to be protected as whistleblowers, and

the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.''.

(b) EFFECTIVE DATE.—Except as provided in section 6035(e), the amendments made by subsection (a) take effect on January 1, 2007.

SEC. 6034. PROHIBITION ON RESTOCKING AND DOUBLE BILLING OF PRESCRIPTION DRUGS.

(a) IN GENERAL.—Section 1903(i)(10) of the Social Security Act (42 U.S.C. 1396b(i)), as amended by section 6002(b), is amended—

(1) in subparagraph (B), by striking ''and'' at the end;

(2) in subparagraph (C), by striking ''; or'' at the end and inserting '', and''; and

(3) by adding at the end the following:

''(D) with respect to any amount expended for reimbursement to a pharmacy under this title for the ingredient cost of a covered outpatient drug for which the pharmacy has already received payment under this title (other than with respect to a reasonable restocking fee for such drug); or''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) take effect on the first day of the first fiscal year quarter that begins after the date of enactment of this Act.

SEC. 6035. MEDICAID INTEGRITY PROGRAM.

(a) ESTABLISHMENT OF MEDICAID INTEGRITY PROGRAM.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended—

(1) by redesignating section 1936 as section 1937; and

(2) by inserting after section 1935 the following:

''MEDICAID INTEGRITY PROGRAM

''SEC. 1936. (a) IN GENERAL.—There is hereby established the Medicaid Integrity Program (in this section referred to as the 'Program') under which the Secretary shall promote the integrity of the program under this title by entering into contracts in accordance with this section with eligible entities to carry out the activities described in subsection (b).

''(b) ACTIVITIES DESCRIBED—Activities described in this subsection are as follows:

''(1) Review of the actions of individuals or entities furnishing items or services (whether on a fee-for-service, risk, or other basis) for which payment may be made under a State plan approved under this title (or under any waiver of such plan approved under section 1115) to determine whether fraud, waste, or abuse has occurred, is likely to occur, or whether such actions have any potential for resulting

in an expenditure of funds under this title in a manner which is not intended under the provisions of this title.

''(2) Audit of claims for payment for items or services furnished, or administrative services rendered, under a State plan under this title, including—

''(A) cost reports;

''(B) consulting contracts; and

''(C) risk contracts under section 1903(m).

''(3) Identification of overpayments to individuals or entities receiving Federal funds under this title.

''(4) Education of providers of services, managed care entities, beneficiaries, and other individuals with respect to payment integrity and quality of care.

''(c) ELIGIBLE ENTITY AND CONTRACTING REQUIREMENTS.—

''(1) IN GENERAL.—An entity is eligible to enter into a contract under the Program to carry out any of the activities described in subsection (b) if the entity satisfies the requirements of paragraphs (2) and (3).

''(2) ELIGIBILITY REQUIREMENTS.—The requirements of this paragraph are the following:

''(A) The entity has demonstrated capability to carry out the activities described in subsection (b).

''(B) In carrying out such activities, the entity agrees to cooperate with the Inspector General of the Department of Health and Human Services, the Attorney General, and other law enforcement agencies, as appropriate, in the investigation and deterrence of fraud and abuse in relation to this title and in other cases arising out of such activities.

''(C) The entity complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement.

''(D) The entity meets such other requirements as the Secretary may impose.

''(3) CONTRACTING REQUIREMENTS.—The entity has contracted with the Secretary in accordance with such procedures as the Secretary shall by regulation establish, except that such procedures shall include the following:

''(A) Procedures for identifying, evaluating, and resolving organizational conflicts of

interest that are generally applicable to Federal acquisition and procurement.

"(B) Competitive procedures to be used—

"(i) when entering into new contracts under this section;

"(ii) when entering into contracts that may result in the elimination of responsibilities under section 202(b) of the Health Insurance Portability and Accountability Act of 1996; and

"(iii) at any other time considered appropriate by the Secretary.

"(C) Procedures under which a contract under this section may be renewed without regard to any provision of law requiring competition if the contractor has met or exceeded the performance requirements established in the current contract.

The Secretary may enter into such contracts without regard to final rules having been promulgated.

"(4) LIMITATION ON CONTRACTOR LIABILITY.—The Secretary shall by regulation provide for the limitation of a contractor's liability for actions taken to carry out a contract under the Program, and such regulation shall, to the extent the Sec-

retary finds appropriate, employ the same or comparable standards and other substantive and procedural provisions as are contained in section 1157.

''(d) COMPREHENSIVE PLAN FOR PROGRAM INTEGRITY.—

''(1) 5-YEAR PLAN.—With respect to the 5 fiscal year period beginning with fiscal year 2006, and each such 5-fiscal year period that begins thereafter, the Secretary shall establish a comprehensive plan for ensuring the integrity of the program established under this title by combatting fraud, waste, and abuse.

''(2) CONSULTATION.—Each 5-fiscal year plan established under paragraph (1) shall be developed by the Secretary in consultation with the Attorney General, the Director of the Federal Bureau of Investigation, the Comptroller General of the United States, the Inspector General of the Department of Health and Human Services, and State officials with responsibility for controlling provider fraud and abuse under State plans under this title.

''(e) APPROPRIATION.—

''(1) IN GENERAL.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated to carry out the

Medicaid Integrity Program under this section, without further appropriation—

''(A) for fiscal year 2006, $5,000,000;

''(B) for each of fiscal years 2007 and 2008, $50,000,000; and

''(C) for each fiscal year thereafter, $75,000,000.

''(2) AVAILABILITY.—Amounts appropriated pursuant to paragraph (1) shall remain available until expended.

''(3) INCREASE IN CMS STAFFING DEVOTED TO PROTECTING MEDICAID PROGRAM INTEGRITY.—From the amounts appropriated under paragraph (1), the Secretary shall increase by 100 the number of full-time equivalent employees whose duties consist solely of protecting the integrity of the Medicaid program established under this section by providing effective support and assistance to States to combat provider fraud and abuse.

''(4) ANNUAL REPORT.—Not later than 180 days after the end of each fiscal year (beginning with fiscal year 2006), the Secretary shall submit a report to Congress which identifies—

''(A) the use of funds appropriated pursuant to paragraph (1); and

''(B) the effectiveness of the use of such funds.''.

(b) STATE REQUIREMENT TO COOPERATE WITH INTEGRITY PROGRAM EFFORTS.—Section 1902(a) of such Act (42 U.S.C. 1396a(a)), as amended by section 6033(a), is amended—

(1) in paragraph (67), by striking ''and'' at the end;

(2) in paragraph (68), by striking the period at the end and inserting ''; and''; and

(3) by inserting after paragraph (68), the following:

''(69) provide that the State must comply with any requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program established under section 1936.''.

(c) INCREASED FUNDING FOR MEDICAID FRAUD AND ABUSE CONTROL ACTIVITIES.—

(1) IN GENERAL.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated to the Office of the Inspector General of the Department of Health and Human Services, without further appropriation, $25,000,000 for each of fiscal years 2006 through 2010, for activities of such Office with respect to the

Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(2) AVAILABILITY; AMOUNTS IN ADDITION TO OTHER AMOUNTS APPROPRIATED FOR SUCH ACTIVITIES.—Amounts appropriated pursuant to paragraph (1) shall—

(A) remain available until expended; and

(B) be in addition to any other amounts appropriated or made available to the Office of the Inspector General of the Department of Health and Human Services for activities of such Office with respect to the Medicaid program.

(3) ANNUAL REPORT.—Not later than 180 days after the end of each fiscal year (beginning with fiscal year 2006), the Inspector General of the Department of Health and Human Services shall submit a report to Congress which identifies—

(A) the use of funds appropriated pursuant to paragraph (1); and

(B) the effectiveness of the use of such funds.

(d) NATIONAL EXPANSION OF THE MEDICARE-MEDICAID (MEDI-MEDI) DATA MATCH PILOT PROGRAM.—

(1) REQUIREMENT OF THE MEDICARE INTEGRITY PROGRAM.—Section 1893 of the Social Security Act (42 U.S.C. 1395ddd) is amended—

(A) in subsection (b), by adding at the end the following:

''(6) The Medicare-Medicaid Data Match Program in accordance with subsection (g).''; and

(B) by adding at the end the following:

''(g) MEDICARE-MEDICAID DATA MATCH PROGRAM.—

''(1) EXPANSION OF PROGRAM.—

''(A) IN GENERAL.—The Secretary shall enter into contracts with eligible entities for the purpose of ensuring that, beginning with 2006, the Medicare-Medicaid Data Match Program (commonly referred to as the 'Medi-Medi Program') is conducted with respect to the program established under this title and State Medicaid programs under title XIX for the purpose of—

''(i) identifying program vulnerabilities in the program established under this title and the Medicaid program established under title XIX through the use of computer algorithms to look for

payment anomalies (including billing or billing patterns identified with respect to service, time, or patient that appear to be suspect or otherwise implausible);

"(ii) working with States, the Attorney General, and the Inspector General of the Department of Health and Human Services to coordinate appropriate actions to protect the Federal and State share of expenditures under the Medicaid program under title XIX, as well as the program established under this title; and

"(iii) increasing the effectiveness and efficiency of both such programs through cost avoidance, savings, and recoupments of fraudulent, wasteful, or abusive expenditures.

"(B) REPORTING REQUIREMENTS.—The Secretary shall make available in a timely manner any data and statistical information collected by the Medi-Medi Program to the Attorney General, the Director of the Federal Bureau of Investigation, the Inspector General of the Department of Health and Human Services, and the States (including a medicaid fraud and

abuse control unit described in section 1903(q)). Such information shall be disseminated no less frequently than quarterly.

''(2) LIMITED WAIVER AUTHORITY.—The Secretary shall waive only such requirements of this section and of titles XI and XIX as are necessary to carry out paragraph (1).''.

(2) FUNDING.—Section 1817(k)(4) of such Act (42 U.S.C. 1395i(k)(4)), as amended by section 5204 of this Act, is amended—

(A) in subparagraph (A), by striking ''subparagraph (B)'' and inserting ''subparagraphs (B), (C), and (D)''; and

(B) by adding at the end the following:

''(D) EXPANSION OF THE MEDICARE-MEDICAID DATA MATCH PROGRAM.—The amount appropriated under subparagraph (A) for a fiscal year is further increased as follows for purposes of carrying out section 1893(b)(6) for the respective fiscal year:

''(i) $12,000,000 for fiscal year 2006.

''(ii) $24,000,000 for fiscal year 2007.

''(iii) $36,000,000 for fiscal year 2008.

"(iv) $48,000,000 for fiscal year 2009.

"(v) $60,000,000 for fiscal year 2010 and each fiscal year thereafter.".

(e) DELAYED EFFECTIVE DATE FOR CHAPTER.—Except as otherwise provided in this chapter, in the case of a State plan under title XIX of the Social Security Act which the Secretary determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by a provision of this chapter, the State plan shall not be regarded as failing to comply with the requirements of such Act solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature.

SEC. 6036. ENHANCING THIRD PARTY IDENTIFICATION AND PAYMENT.

(a) CLARIFICATION OF THIRD PARTIES LEGALLY RESPONSIBLE FOR PAYMENT OF A CLAIM FOR A HEALTH

CARE ITEM OR SERVICE.—Section 1902(a)(25) of the Social Security Act (42 U.S.C. 1396a(a)(25)) is amended—

(1) in subparagraph (A), in the matter preceding clause (i)—

(A) by inserting ", self-insured plans" after "health insurers"; and

(B) by striking "and health maintenance organizations" and inserting "managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service"; and

(2) in subparagraph (G)—

(A) by inserting "a self-insured plan," after "1974,"; and

(B) by striking "and a health maintenance organization" and inserting "a managed care organization, a pharmacy benefit manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service".

(b) REQUIREMENT FOR THIRD PARTIES TO PROVIDE THE STATE WITH COVERAGE ELIGIBILITY AND CLAIMS DATA.—Section 1902(a)(25) of such Act (42 U.S.C. 1396a(a)(25)) is amended—

(1) in subparagraph (G), by striking ''and'' at the end;

(2) in subparagraph (H), by adding ''and'' after the semicolon at the end; and

(3) by inserting after subparagraph (H), the following:

''(I) that the State shall provide assurances satisfactory to the Secretary that the State has in effect laws requiring health insurers, including self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service, as a condition of doing business in the State, to—

''(i) provide, with respect to individuals who are eligible for, or are provided, medical assistance under the State plan, upon the request of the State, information to determine during what period the individual or their spouses or their dependents may be (or may have been) covered by a

health insurer and the nature of the coverage that is or was provided by the health insurer (including the name, address, and identifying number of the plan) in a manner prescribed by the Secretary;

''(ii) accept the State's right of recovery and the assignment to the State of any right of an individual or other entity to payment from the party for an item or service for which payment has been made under the State plan;

''(iii) respond to any inquiry by the State regarding a claim for payment for any health care item or service that is submitted not later than 3 years after the date of the provision of such health care item or service; and

''(iv) agree not to deny a claim submitted by the State solely on the basis of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point-of-sale that is the basis of the claim, if—

"(I) the claim is submitted by the State within the 3-year period beginning on the date on which the item or service was furnished; and

"(II) any action by the State to enforce its rights with respect to such claim is commenced within 6 years of the State's submission of such claim;".

(c) EFFECTIVE DATE.—Except as provided in section 6035(e), the amendments made by this section take effect on January 1, 2006.

SEC. 6037. IMPROVED ENFORCEMENT OF DOCUMENTATION REQUIREMENTS.

(a) IN GENERAL.—Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended—

(1) in subsection (i), as amended by section 104 of Public Law 109–91 and section 6031(a) of this Act—

(A) by striking "or" at the end of paragraph (21);

(B) by striking the period at the end of paragraph (22) and inserting "; or"; and

(C) by inserting after paragraph (22) the following new paragraph:

''(23) with respect to amounts expended for medical assistance for an individual who declares under section 1137(d)(1)(A) to be a citizen or national of the United States for purposes of establishing eligibility for benefits under this title, unless the requirement of subsection (x) is met.''; and

(2) by adding at the end the following new subsection:

''(x)(1) For purposes of subsection (i)(23), the requirement of this subsection is, with respect to an individual declaring to be a citizen or national of the United States, that, subject to paragraph (2), there is presented satisfactory documentary evidence of citizenship or nationality (as defined in paragraph (3)) of the individual.

''(2) The requirement of paragraph (1) shall not apply to an alien who is eligible for medical assistance under this title—

''(A) and is entitled to or enrolled for benefits under any part of title XVIII;

''(B) on the basis of receiving supplemental security income benefits under title XVI; or

''(C) on such other basis as the Secretary may specify under which satisfactory documentary evidence of citizenship or nationality had been previously presented.

''(3)(A) For purposes of this subsection, the term 'satisfactory documentary evidence of citizenship or nationality' means—

''(i) any document described in subparagraph (B); or

''(ii) a document described in subparagraph (C) and a document described in subparagraph (D).

''(B) The following are documents described in this subparagraph:

''(i) A United States passport.

''(ii) Form N–550 or N–570 (Certificate of Naturalization).

''(iii) Form N–560 or N–561 (Certificate of United States Citizenship).

''(iv) A valid State-issued driver's license or other identity document described in section 274A(b)(1)(D) of the Immigration and Nationality Act, but only if the State issuing the license or such document requires proof of United States citizenship before issuance of such license or document or obtains a social security number from the applicant and verifies before certification that such number is valid and assigned to the applicant who is a citizen.

''(v) Such other document as the Secretary may specify, by regulation, that provides proof of United

States citizenship or nationality and that provides a reliable means of documentation of personal identity.

''(C) The following are documents described in this subparagraph:

''(i) A certificate of birth in the United States.

''(ii) Form FS–545 or Form DS–1350 (Certification of Birth Abroad).

''(iii) Form I–97 (United States Citizen Identification Card).

''(iv) Form FS–240 (Report of Birth Abroad of a Citizen of the United States).

''(v) Such other document (not described in subparagraph (B)(iv)) as the Secretary may specify that provides proof of United States citizenship or nationality.

''(D) The following are documents described in this subparagraph:

''(i) Any identity document described in section 274A(b)(1)(D) of the Immigration and Nationality Act.

''(ii) Any other documentation of personal identity of such other type as the Secretary finds, by regulation, provides a reliable means of identification.

''(E) A reference in this paragraph to a form includes a reference to any successor form.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to determinations of initial eligibility for medical assistance made on or after July 1, 2006, and to redeterminations of eligibility made on or after such date in the case of individuals for whom the requirement of section 1903(z) of the Social Security Act, as added by such amendments, was not previously met.

(c) IMPLEMENTATION REQUIREMENT.—As soon as practicable after the date of enactment of this Act, the Secretary of Health and Human Services shall establish an outreach program that is designed to educate individuals who are likely to be affected by the requirements of subsections (i)(23) and (x) of section 1903 of the Social Security Act (as added by subsection (a)) about such requirements and how they may be satisfied.

CHAPTER 4—FLEXIBILITY IN COST SHARING AND BENEFITS

SEC. 6041. STATE OPTION FOR ALTERNATIVE MEDICAID PREMIUMS AND COST SHARING.

(a) IN GENERAL.—Title XIX of the Social Security Act is amended by inserting after section 1916 the following new section:

''STATE OPTION FOR ALTERNATIVE PREMIUMS AND COST SHARING

''SEC. 1916A. (a) STATE FLEXIBILITY.—

''(1) IN GENERAL.—Notwithstanding sections 1916 and 1902(a)(10)(B), a State, at its option and through a State plan amendment, may impose premiums and cost sharing for any group of individuals (as specified by the State) and for any type of services (other than drugs for which cost sharing may be imposed under subsection (c)), and may vary such premiums and cost sharing among such groups or types, consistent with the limitations established under this section. Nothing in this section shall be construed as superseding (or preventing the application of) section 1916(g).

''(2) DEFINITIONS.—In this section:

''(A) PREMIUM.—The term 'premium' includes any enrollment fee or similar charge.

''(B) COST SHARING.—The term 'cost sharing' includes any deduction, copayment, or similar charge.

''(b) LIMITATIONS ON EXERCISE OF AUTHORITY.—

''(1) INDIVIDUALS WITH FAMILY INCOME BETWEEN 100 AND 150 PERCENT OF THE POVERTY LINE.—In the case of an individual whose family in-

come exceeds 100 percent, but does not exceed 150 percent, of the poverty line applicable to a family of the size involved, subject to subsections (c)(2) and (e)(2)(A)—

"(A) no premium may be imposed under the plan; and

"(B) with respect to cost sharing—

"(i) the cost sharing imposed under subsection (a) with respect to any item or service may not exceed 10 percent of the cost of such item or service; and

"(ii) the total aggregate amount of cost sharing imposed under this section (including any cost sharing imposed under subsection (c) or (e)) for all individuals in the family may not exceed 5 percent of the family income of the family involved, as applied on a quarterly or monthly basis (as specified by the State).

"(2) INDIVIDUALS WITH FAMILY INCOME ABOVE 150 PERCENT OF THE POVERTY LINE.—In the case of an individual whose family income exceeds 150 percent of the poverty line applicable to a family of the size involved, subject to subsections (c)(2) and (e)(2)(A)—

"(A) the total aggregate amount of premiums and cost sharing imposed under this section (including any cost sharing imposed under subsection (c) or (e)) for all individuals in the family may not exceed 5 percent of the family income of the family involved, as applied on a quarterly or monthly basis (as specified by the State); and

"(B) with respect to cost sharing, the cost sharing imposed with respect to any item or service under subsection (a) may not exceed 20 percent of the cost of such item or service.

"(3) ADDITIONAL LIMITATIONS.—

"(A) PREMIUMS.—No premiums shall be imposed under this section with respect to the following:

"(i) Individuals under 18 years of age that are required to be provided medical assistance under section 1902(a)(10)(A)(i), and including individuals with respect to whom aid or assistance is made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is

made available under part E of such title, without regard to age.

"(ii) Pregnant women.

"(iii) Any terminally ill individual who is receiving hospice care (as defined in section 1905(o)).

"(iv) Any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

"(v) Women who are receiving medical assistance by virtue of the application of sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa).

"(B) COST SHARING.—Subject to the succeeding provisions of this section, no cost sharing shall be imposed under subsection (a) with respect to the following:

''(i) Services furnished to individuals under 18 years of age that are required to be provided medical assistance under section 1902(a)(10)(A)(i), and including services furnished to individuals with respect to whom aid or assistance is made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of such title, without regard to age.

''(ii) Preventive services (such as well baby and well child care and immunizations) provided to children under 18 years of age regardless of family income.

''(iii) Services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy.

''(iv) Services furnished to a terminally ill individual who is receiving hospice care (as defined in section 1905(o)).

''(v) Services furnished to any individual who is an inpatient in a hospital, nursing facility, intermediate care facility

for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

''(vi) Emergency services (as defined by the Secretary for purposes of section 1916(a)(2)(D)).

''(vii) Family planning services and supplies described in section 1905(a)(4)(C).

''(viii) Services furnished to women who are receiving medical assistance by virtue of the application of sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa).

''(C) CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing a State from exempting additional classes of individuals from premiums under this section or from exempting additional individuals or services from cost sharing under subsection (a).

''(4) DETERMINATIONS OF FAMILY INCOME.—In applying this subsection, family income shall be

determined in a manner specified by the State for purposes of this subsection, including the use of such disregards as the State may provide. Family income shall be determined for such period and at such periodicity as the State may provide under this title.

''(5) POVERTY LINE DEFINED.—For purposes of this section, the term 'poverty line' has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

''(6) CONSTRUCTION.—Nothing in this section shall be construed—

''(A) as preventing a State from further limiting the premiums and cost sharing imposed under this section beyond the limitations provided under this section;

''(B) as affecting the authority of the Secretary through waiver to modify limitations on premiums and cost sharing under this section; or

''(C) as affecting any such waiver of requirements in effect under this title before the date of the enactment of this section with re-

gard to the imposition of premiums and cost sharing.

''(d) ENFORCEABILITY OF PREMIUMS AND OTHER COST SHARING.—

''(1) PREMIUMS.—Notwithstanding section 1916(c)(3) and section 1902(a)(10)(B), a State may, at its option, condition the provision of medical assistance for an individual upon prepayment of a premium authorized to be imposed under this section, or may terminate eligibility for such medical assistance on the basis of failure to pay such a premium but shall not terminate eligibility of an individual for medical assistance under this title on the basis of failure to pay any such premium until such failure continues for a period of not less than 60 days. A State may apply the previous sentence for some or all groups of beneficiaries as specified by the State and may waive payment of any such premium in any case where the State determines that requiring such payment would create an undue hardship.

''(2) COST SHARING.—Notwithstanding section 1916(e) or any other provision of law, a State may permit a provider participating under the State plan to require, as a condition for the provision of care,

items, or services to an individual entitled to medical assistance under this title for such care, items, or services, the payment of any cost sharing authorized to be imposed under this section with respect to such care, items, or services. Nothing in this paragraph shall be construed as preventing a provider from reducing or waiving the application of such cost sharing on a case-by-case basis.''.

(b) INDEXING NOMINAL COST SHARING AND CONFORMING AMENDMENT.—Section 1916 of such Act (42 U.S.C. 1396o) is amended—

(1) in subsection (f), by inserting ''and section 1916A'' after ''(b)(3)''; and

(2) by adding at the end the following new subsection:

''(h) In applying this section and subsections (c) and (e) of section 1916A, with respect to cost sharing that is 'nominal' in amount, the Secretary shall increase such 'nominal' amounts for each year (beginning with 2006) by the annual percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) as rounded up in an appropriate manner.''.

(c) GAO STUDY OF IMPACT OF PREMIUMS AND COST SHARING.—The Comptroller General of the United States

shall conduct a study on the impact of premiums and cost sharing under the Medicaid program on access to, and utilization of, services. Not later than January 1, 2008, the Comptroller General shall submit to Congress a report on such study.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to cost sharing imposed for items and services furnished on or after March 31, 2006.

SEC. 6042. SPECIAL RULES FOR COST SHARING FOR PRESCRIPTION DRUGS.

(a) IN GENERAL.—Section 1916A of the Social Security Act, as inserted by section 6041(a), is amended by inserting after subsection (b) the following new subsection:

''(c) SPECIAL RULES FOR COST SHARING FOR PRESCRIPTION DRUGS.—

''(1) IN GENERAL.—In order to encourage beneficiaries to use drugs (in this subsection referred to as 'preferred drugs') identified by the State as the least (or less) costly effective prescription drugs within a class of drugs (as defined by the State), with respect to one or more groups of beneficiaries specified by the State, subject to paragraph (2), the State may—

''(A) provide cost sharing (instead of the level of cost sharing otherwise permitted under

section 1916, but subject to paragraphs (2) and (3)) with respect to drugs that are not preferred drugs within a class; and

''(B) waive or reduce the cost sharing otherwise applicable for preferred drugs within such class and shall not apply any such cost sharing for such preferred drugs for individuals for whom cost sharing may not otherwise be imposed under subsection (b)(3)(B).

''(2) LIMITATIONS.—

''(A) BY INCOME GROUP.—In no case may the cost sharing under paragraph (1)(A) with respect to a non-preferred drug exceed—

''(i) in the case of an individual whose family income does not exceed 150 percent of the poverty line applicable to a family of the size involved, the amount of nominal cost sharing (as otherwise determined under section 1916); or

''(ii) in the case of an individual whose family income exceeds 150 percent of the poverty line applicable to a family of the size involved, 20 percent of the cost of the drug.

"(B) LIMITATION TO NOMINAL FOR EXEMPT POPULATIONS.—In the case of an individual who is otherwise not subject to cost sharing due to the application of subsection (b)(3)(B), any cost sharing under paragraph (1)(A) with respect to a non-preferred drug may not exceed a nominal amount (as otherwise determined under section 1916).

"(C) CONTINUED APPLICATION OF AGGREGATE CAP.—In addition to the limitations imposed under subparagraphs (A) and (B), any cost sharing under paragraph (1)(A) continues to be subject to the aggregate cap on cost sharing applied under paragraph (1) or (2) of subsection (b), as the case may be.

"(3) WAIVER.—In carrying out paragraph (1), a State shall provide for the application of cost sharing levels applicable to a preferred drug in the case of a drug that is not a preferred drug if the prescribing physician determines that the preferred drug for treatment of the same condition either would not be as effective for the individual or would have adverse effects for the individual or both.

"(4) EXCLUSION AUTHORITY.—Nothing in this subsection shall be construed as preventing a State

from excluding specified drugs or classes of drugs from the application of paragraph (1).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to cost sharing imposed for items and services furnished on or after March 31, 2006.

SEC. 6043. EMERGENCY ROOM COPAYMENTS FOR NON-EMERGENCY CARE.

(a) IN GENERAL.—Section 1916A of the Social Security Act, as inserted by section 6041 and as amended by section 6042, is further amended by adding at the end the following new subsection:

''(e) STATE OPTION FOR PERMITTING HOSPITALS TO IMPOSE COST SHARING FOR NON-EMERGENCY CARE FURNISHED IN AN EMERGENCY DEPARTMENT.—

''(1) IN GENERAL.—Notwithstanding section 1916 and section 1902(a)(1) or the previous provisions of this section, but subject to the limitations of paragraph (2), a State may, by amendment to its State plan under this title, permit a hospital to impose cost sharing for non-emergency services furnished to an individual (within one or more groups of individuals specified by the State) in the hospital emergency department under this subsection if the following conditions are met:

"(A) ACCESS TO NON-EMERGENCY ROOM PROVIDER.—The individual has actually available and accessible (as such terms are applied by the Secretary under section 1916(b)(3)) an alternate non-emergency services provider with respect to such services.

"(B) NOTICE.—The hospital must inform the beneficiary after receiving an appropriate medical screening examination under section 1867 and after a determination has been made that the individual does not have an emergency medical condition, but before providing the non-emergency services, of the following:

"(i) The hospital may require the payment of the State specified cost sharing before the service can be provided.

"(ii) The name and location of an alternate non-emergency services provider (described in subparagraph (A)) that is actually available and accessible (as described in such subparagraph).

"(iii) The fact that such alternate provider can provide the services without the imposition of cost sharing described in clause (i).

"(iv) The hospital provides a referral to coordinate scheduling of this treatment.

Nothing in this subsection shall be construed as preventing a State from applying (or waiving) cost sharing otherwise permissible under this section to services described in clause (iii).

"(2) LIMITATIONS.—

"(A) FOR POOREST BENEFICIARIES.—In the case of an individual described in subsection (b)(1), the cost sharing imposed under this subsection may not exceed twice the amount determined to be nominal under section 1916, subject to the percent of income limitation otherwise applicable under subsection (b)(1).

"(B) APPLICATION TO EXEMPT POPULATIONS.—In the case of an individual who is otherwise not subject to cost sharing under subsection (b)(3), a State may impose cost sharing under paragraph (1) for care in an amount that does not exceed a nominal amount (as otherwise determined under section 1916) so long as no cost sharing is imposed to receive such care through an outpatient department or other alternative health care provider in the geographic

area of the hospital emergency department involved.

''(C) CONTINUED APPLICATION OF AGGREGATE CAP; RELATION TO OTHER COST SHARING.—In addition to the limitations imposed under subparagraphs (A) and (B), any cost sharing under paragraph (1) is subject to the aggregate cap on cost sharing applied under paragraph (1) or (2) of subsection (b), as the case may be. Cost sharing imposed for services under this subsection shall be instead of any cost sharing that may be imposed for such services under subsection (a).

''(3) CONSTRUCTION.—Nothing in this section shall be construed—

''(A) to limit a hospital's obligations with respect to screening and stabilizing treatment of an emergency medical condition under section 1867; or

''(B) to modify any obligations under either State or Federal standards relating to the application of a prudent-layperson standard with respect to payment or coverage of emergency services by any managed care organization.

''(4) STANDARD REGARDING IMPOSITION OF COST SHARING.—No hospital or physician shall be liable in any civil action or proceeding for the imposition of cost-sharing under this section, absent a finding by clear and convincing evidence of gross negligence by the hospital or physician. The previous sentence shall not affect any liability under section 1867 or otherwise applicable under State law based upon the provision of (or failure to provide) care.

''(5) DEFINITIONS.—For purposes of this subsection:

''(A) NON-EMERGENCY SERVICES.—The term 'non-emergency services' means any care or services furnished in a emergency department of a hospital that the physician determines do not constitute an appropriate medical screening examination or stabilizing examination and treatment required to be provided by the hospital under section 1867.

''(B) ALTERNATE NON-EMERGENCY SERVICES PROVIDER.—The term 'alternative non-emergency services provider' means, with respect to non-emergency services for the diagnosis or treatment of a condition, a health care provider, such as a physician's office, health

care clinic, community health center, hospital outpatient department, or similar health care provider, that can provide clinically appropriate services for the diagnosis or treatment of a condition contemporaneously with the provision of the non-emergency services that would be provided in a emergency department of a hospital for the diagnosis or treatment of a condition, and that is participating in the program under this title.''.

(b) GRANT FUNDS FOR ESTABLISHMENT OF ALTERNATE NON-EMERGENCY SERVICES PROVIDERS.—Section 1903 of the Social Security Act (42 U.S.C. 1396b), as amended by section 6037(a)(2), is amended by adding at the end the following new subsection:

''(y) PAYMENTS FOR ESTABLISHMENT OF ALTERNATE NON-EMERGENCY SERVICES PROVIDERS.—

''(1) PAYMENTS.—In addition to the payments otherwise provided under subsection (a), subject to paragraph (2), the Secretary shall provide for payments to States under such subsection for the establishment of alternate non-emergency service providers (as defined in section 1916A(e)(5)(B)), or networks of such providers.

''(2) LIMITATION.—The total amount of payments under this subsection shall not exceed $50,000,000 during the 4-year period beginning with 2006. This subsection constitutes budget authority in advance of appropriations Acts and represents the obligation of the Secretary to provide for the payment of amounts provided under this subsection.

''(3) PREFERENCE.—In providing for payments to States under this subsection, the Secretary shall provide preference to States that establish, or provide for, alternate non-emergency services providers or networks of such providers that—

''(A) serve rural or underserved areas where beneficiaries under this title may not have regular access to providers of primary care services; or

''(B) are in partnership with local community hospitals.

''(4) FORM AND MANNER OF PAYMENT.—Payment to a State under this subsection shall be made only upon the filing of such application in such form and in such manner as the Secretary shall specify. Payment to a State under this subsection shall be

made in the same manner as other payments under section 1903(a).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to non-emergency services furnished on or after January 1, 2007.

SEC. 6044. USE OF BENCHMARK BENEFIT PACKAGES.

(a) IN GENERAL.—Title XIX of the Social Security Act, as amended by section 6035, is amended by redesignating section 1937 as section 1938 and by inserting after section 1936 the following new section:

''STATE FLEXIBILITY IN BENEFIT PACKAGES

''SEC. 1937. (a) STATE OPTION OF PROVIDING BENCHMARK BENEFITS.—

''(1) AUTHORITY.—

''(A) IN GENERAL.—Notwithstanding any other provision of this title, a State, at its option as a State plan amendment, may provide for medical assistance under this title to individuals within one or more groups of individuals specified by the State through enrollment in coverage that provides—

''(i) benchmark coverage described in subsection (b)(1) or benchmark equivalent coverage described in subsection (b)(2); and

''(ii) for any child under 19 years of age who is covered under the State plan under section 1902(a)(10)(A), wrap-around benefits to the benchmark coverage or benchmark equivalent coverage consisting of early and periodic screening, diagnostic, and treatment services defined in section 1905(r).

''(B) LIMITATION.—The State may only exercise the option under subparagraph (A) for an individual eligible under an eligibility category that had been established under the State plan on or before the date of the enactment of this section.

''(C) OPTION OF WRAP-AROUND BENEFITS.—In the case of coverage described in subparagraph (A), a State, at its option, may provide such wrap-around or additional benefits as the State may specify.

''(D) TREATMENT AS MEDICAL ASSISTANCE.—Payment of premiums for such coverage under this subsection shall be treated as payment of other insurance premiums described in the third sentence of section 1905(a).

''(2) APPLICATION.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), a State may require that a full-benefit eligible individual (as defined in subparagraph (C)) within a group obtain benefits under this title through enrollment in coverage described in paragraph (1)(A). A State may apply the previous sentence to individuals within 1 or more groups of such individuals.

"(B) LIMITATION ON APPLICATION.—A State may not require under subparagraph (A) an individual to obtain benefits through enrollment described in paragraph (1)(A) if the individual is within one of the following categories of individuals:

"(i) MANDATORY PREGNANT WOMEN.—The individual is a pregnant woman who is required to be covered under the State plan under section 1902(a)(10)(A)(i).

"(ii) BLIND OR DISABLED INDIVIDUALS.—The individual qualifies for medical assistance under the State plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible

for supplemental security income benefits under title XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of section 1902(e)(3).

''(iii) DUAL ELIGIBLES.—The individual is entitled to benefits under any part of title XVIII.

''(iv) TERMINALLY ILL HOSPICE PATIENTS.—The individual is terminally ill and is receiving benefits for hospice care under this title.

''(v) ELIGIBLE ON BASIS OF INSTITUTIONALIZATION.—The individual is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, and is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

''(vi) MEDICALLY FRAIL AND SPECIAL MEDICAL NEEDS INDIVIDUALS.—The individual is medically frail or otherwise an in-

dividual with special medical needs (as identified in accordance with regulations of the Secretary).

''(vii) BENEFICIARIES QUALIFYING FOR LONG-TERM CARE SERVICES.—The individual qualifies based on medical condition for medical assistance for long-term care services described in section 1917(c)(1)(C).

''(viii) CHILDREN IN FOSTER CARE RECEIVING CHILD WELFARE SERVICES AND CHILDREN RECEIVING FOSTER CARE OR ADOPTION ASSISTANCE.—The individual is an individual with respect to whom aid or assistance is made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of such such title, without regard to age.

''(ix) TANF AND SECTION 1931 PARENTS.—The individual qualifies for medical assistance on the basis of eligibility to receive assistance under a State plan funded under part A of title IV (as in effect on

or after the welfare reform effective date defined in section 1931(i)).

''(x) WOMEN IN THE BREAST OR CERVICAL CANCER PROGRAM.—The individual is a woman who is receiving medical assistance by virtue of the application of sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa).

''(xii) LIMITED SERVICES BENEFICIARIES.—The individual—

''(I) qualifies for medical assistance on the basis of section 1902(a)(10)(A)(ii)(XII); or

''(II) is not a qualified alien (as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996) and receives care and services necessary for the treatment of an emergency medical condition in accordance with section 1903(v).

''(C) FULL-BENEFIT ELIGIBLE INDIVIDUALS.—

''(i) IN GENERAL.—For purposes of this paragraph, subject to clause (ii), the

term 'full-benefit eligible individual' means for a State for a month an individual who is determined eligible by the State for medical assistance for all services defined in section 1905(a) which are covered under the State plan under this title for such month under section 1902(a)(10)(A) or under any other category of eligibility for medical assistance for all such services under this title, as determined by the Secretary.

''(ii) EXCLUSION OF MEDICALLY NEEDY AND SPEND-DOWN POPULATIONS.—Such term shall not include an individual determined to be eligible by the State for medical assistance under section 1902(a)(10)(C) or by reason of section 1902(f) or otherwise eligible based on a reduction of income based on costs incurred for medical or other remedial care.

''(b) BENCHMARK BENEFIT PACKAGES.—

''(1) IN GENERAL.—For purposes of subsection (a)(1), each of the following coverage shall be considered to be benchmark coverage:

''(A) FEHBP-EQUIVALENT HEALTH INSURANCE COVERAGE.—The standard Blue Cross/Blue Shield preferred provider option service benefit plan, described in and offered under section 8903(1) of title 5, United States Code.

''(B) STATE EMPLOYEE COVERAGE.—A health benefits coverage plan that is offered and generally available to State employees in the State involved.

''(C) COVERAGE OFFERED THROUGH HMO.—The health insurance coverage plan that—

''(i) is offered by a health maintenance organization (as defined in section 2791(b)(3) of the Public Health Service Act), and

''(ii) has the largest insured commercial, non-medicaid enrollment of covered lives of such coverage plans offered by such a health maintenance organization in the State involved.

''(D) SECRETARY-APPROVED COVERAGE.—Any other health benefits coverage that the Secretary determines, upon application by a State,

provides appropriate coverage for the population proposed to be provided such coverage.

"(2) BENCHMARK-EQUIVALENT COVERAGE.—For purposes of subsection (a)(1), coverage that meets the following requirement shall be considered to be benchmark-equivalent coverage:

"(A) INCLUSION OF BASIC SERVICES.—The coverage includes benefits for items and services within each of the following categories of basic services:

"(i) Inpatient and outpatient hospital services.

"(ii) Physicians' surgical and medical services.

"(iii) Laboratory and x-ray services.

"(iv) Well-baby and well-child care, including age-appropriate immunizations.

"(v) Other appropriate preventive services, as designated by the Secretary.

"(B) AGGREGATE ACTUARIAL VALUE EQUIVALENT TO BENCHMARK PACKAGE.—The coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages described in paragraph (1).

''(C) SUBSTANTIAL ACTUARIAL VALUE FOR ADDITIONAL SERVICES INCLUDED IN BENCHMARK PACKAGE.—With respect to each of the following categories of additional services for which coverage is provided under the benchmark benefit package used under subparagraph (B), the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the coverage of that category of services in such package:

''(i) Coverage of prescription drugs.

''(ii) Mental health services.

''(iii) Vision services.

''(iv) Hearing services.

''(3) DETERMINATION OF ACTUARIAL VALUE.—The actuarial value of coverage of benchmark benefit packages shall be set forth in an actuarial opinion in an actuarial report that has been prepared—

''(A) by an individual who is a member of the American Academy of Actuaries;

''(B) using generally accepted actuarial principles and methodologies;

''(C) using a standardized set of utilization and price factors;

"(D) using a standardized population that is representative of the population involved;

"(E) applying the same principles and factors in comparing the value of different coverage (or categories of services);

"(F) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and

"(G) taking into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under this title that results from the limitations on cost sharing under such coverage.

The actuary preparing the opinion shall select and specify in the memorandum the standardized set and population to be used under subparagraphs (C) and (D).

"(4) COVERAGE OF RURAL HEALTH CLINIC AND FQHC SERVICES.—Notwithstanding the previous provisions of this section, a State may not provide for medical assistance through enrollment of an individual with benchmark coverage or benchmark equivalent coverage under this section unless—

''(A) the individual has access, through such coverage or otherwise, to services described in subparagraphs (B) and (C) of section 1905(a)(2); and

''(B) payment for such services is made in accordance with the requirements of section 1902(bb).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) takes effect on March 31, 2006.

CHAPTER 5—STATE FINANCING UNDER MEDICAID

SEC. 6051. MANAGED CARE ORGANIZATION PROVIDER TAX REFORM.

(a) IN GENERAL.—Section 1903(w)(7)(A)(viii) of the Social Security Act (42 U.S.C. 1396b(w)(7)(A)(viii)) is amended to read as follows:

''(viii) Services of managed care organizations (including health maintenance organizations, preferred provider organizations, and such other similar organizations as the Secretary may specify by regulation).''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Subject to paragraph (2), the amendment made by subsection (a) shall be effective as of the date of the enactment of this Act.

(2) DELAY IN EFFECTIVE DATE.—

(A) IN GENERAL.—Subject to subparagraph (B), in the case of a State specified in subparagraph (B), the amendment made by subsection (a) shall be effective as of October 1, 2009.

(B) SPECIFIED STATES.—For purposes of subparagraph (A), the States specified in this subparagraph are States that have enacted a law providing for a tax on the services of a medicaid managed care organization with a contract under section 1903(m) of the Social Security Act as of December 8, 2005.

(c) CLARIFICATION REGARDING NON-REGULATION OF TRANSFERS.—

(1) IN GENERAL.—Nothing in section 1903(w) of the Social Security Act (42 U.S.C. 1396b(w)) shall be construed by the Secretary of Health and Human Services as prohibiting a State's use of funds as the non-Federal share of expenditures under title XIX of such Act where such funds are transferred from or certified by a publicly-owned regional medical center located in another State and described in paragraph (2), so long as the Secretary

determines that such use of funds is proper and in the interest of the program under title XIX.

(2) CENTER DESCRIBED.—A center described in this paragraph is a publicly-owned regional medical center that—

(A) provides level 1 trauma and burn care services;

(B) provides level 3 neonatal care services;

(C) is obligated to serve all patients, regardless of State of origin;

(D) is located within a Standard Metropolitan Statistical Area (SMSA) that includes at least 3 States, including the States described in paragraph (1);

(E) serves as a tertiary care provider for patients residing within a 125 mile radius; and

(F) meets the criteria for a disproportionate share hospital under section 1923 of such Act in at least one State other than the one in which the center is located.

(3) EFFECTIVE PERIOD.—This subsection shall apply through December 31, 2006.

SEC. 6052. REFORMS OF CASE MANAGEMENT AND TARGETED CASE MANAGEMENT.

(a) IN GENERAL.—Section 1915(g) of the Social Security Act (42 U.S.C. 1396n(g)(2)) is amended by striking paragraph (2) and inserting the following:

''(2) For purposes of this subsection:

''(A)(i) The term 'case management services' means services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services.

''(ii) Such term includes the following:

''(I) Assessment of an eligible individual to determine service needs, including activities that focus on needs identification, to determine the need for any medical, educational, social, or other services. Such assessment activities include the following:

''(aa) Taking client history.

''(bb) Identifying the needs of the individual, and completing related documentation.

''(cc) Gathering information from other sources such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the eligible individual.

''(II) Development of a specific care plan based on the information collected through an assessment, that specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual, including activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual's authorized health care decision maker) and others to develop such goals and identify a course of action to respond to the assessed needs of the eligible individual.

''(III) Referral and related activities to help an individual obtain needed services, including activities that help link eligible individuals with medical, social, educational providers or other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

''(IV) Monitoring and followup activities, including activities and contacts that are necessary to ensure the care plan is effectively implemented and adequately addressing the needs of the eligible individual, and which may be

with the individual, family members, providers, or other entities and conducted as frequently as necessary to help determine such matters as—

''(aa) whether services are being furnished in accordance with an individual's care plan;

''(bb) whether the services in the care plan are adequate; and

''(cc) whether there are changes in the needs or status of the eligible individual, and if so, making necessary adjustments in the care plan and service arrangements with providers.

''(iii) Such term does not include the direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred, including, with respect to the direct delivery of foster care services, services such as (but not limited to) the following:

''(I) Research gathering and completion of documentation required by the foster care program.

''(II) Assessing adoption placements.

''(III) Recruiting or interviewing potential foster care parents.

''(IV) Serving legal papers.

''(V) Home investigations.

''(VI) Providing transportation.

''(VII) Administering foster care subsidies.

''(VIII) Making placement arrangements.

''(B) The term 'targeted case management services' are case management services that are furnished without regard to the requirements of section 1902(a)(1) and section 1902(a)(10)(B) to specific classes of individuals or to individuals who reside in specified areas.

''(3) With respect to contacts with individuals who are not eligible for medical assistance under the State plan or, in the case of targeted case management services, individuals who are eligible for such assistance but are not part of the target population specified in the State plan, such contacts—

''(A) are considered an allowable case management activity, when the purpose of the contact is directly related to the management of the eligible individual's care; and

''(B) are not considered an allowable case management activity if such contacts relate directly to the identification and management of the noneligible or nontargeted individual's needs and care.

''(4)(A) In accordance with section 1902(a)(25), Federal financial participation only is available under this title for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program.

''(B) A State shall allocate the costs of any part of such services which are reimbursable under another federally funded program in accordance with OMB Circular A–87 (or any related or successor guidance or regulations regarding allocation of costs among federally funded programs) under an approved cost allocation program.

''(5) Nothing in this subsection shall be construed as affecting the application of rules with respect to third party liability under programs, or activities carried out under title XXVI of the Public Health Service Act or by the Indian Health Service.''.

(b) REGULATIONS.—The Secretary shall promulgate regulations to carry out the amendment made by subsection (a) which may be effective and final immediately on an interim basis as of the date of publication of the interim final regulation. If the Secretary provides for an interim final regulation, the Secretary shall provide for a period of public comments on such regulation after the date of publication. The Secretary may change or revise

such regulation after completion of the period of public comment.

(c) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on January 1, 2006.

SEC. 6053. ADDITIONAL FMAP ADJUSTMENTS.

(a) HOLD HARMLESS FOR CERTAIN DECREASE.—Notwithstanding the first sentence of section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)), if, for purposes of titles XIX and XXI of the Social Security Act (42 U.S.C. 1396 et seq., 1397aa et seq.), the Federal medical assistance percentage determined for the State specified in section 4725(a) of Public Law 105-33 for fiscal year 2006 or fiscal year 2007 is less than the Federal medical assistance percentage determined for such State for fiscal year 2005, the Federal medical assistance percentage determined for such State for fiscal year 2005 shall be substituted for the Federal medical assistance percentage otherwise determined for such State for fiscal year 2006 or fiscal year 2007, as the case may be.

(b) HOLD HARMLESS FOR KATRINA IMPACT.—Notwithstanding any other provision of law, for purposes of titles XIX and XXI of the Social Security Act, the Secretary of Health and Human Services, in computing the Federal medical assistance percentage under section 1905(b) of such Act (42 U.S.C. 1396d(b)) for any year

after 2006 for a State that the Secretary determines has a significant number of evacuees who were evacuated to, and live in, the State as a result of Hurricane Katrina as of October 1, 2005, shall disregard such evacuees (and income attributable to such evacuees) from such computation.

SEC. 6054. DSH ALLOTMENT FOR THE DISTRICT OF COLUMBIA.

(a) IN GENERAL.—For purposes of determining the DSH allotment for the District of Columbia under section 1923 of the Social Security Act (42 U.S.C. 1396r–4) for fiscal year 2006 and each subsequent fiscal year, the table in subsection (f)(2) of such section is amended under each of the columns for FY 00, FY 01, and FY 02, in the entry for the District of Columbia by striking ''32'' and inserting ''49''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect as if enacted on October 1, 2005, and shall only apply to disproportionate share hospital adjustment expenditures applicable to fiscal year 2006 and subsequent fiscal years made on or after that date.

SEC. 6055. INCREASE IN MEDICAID PAYMENTS TO INSULAR AREAS.

Section 1108(g) of the Social Security Act (42 U.S.C. 1308(g)) is amended—

(1) in paragraph (2), by inserting ''and subject to paragraph (3)'' after ''subsection (f)''; and

(2) by adding at the end the following new paragraph:

''(3) FISCAL YEARS 2006 AND 2007 FOR CERTAIN INSULAR AREAS.—The amounts otherwise determined under this subsection for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa for fiscal year 2006 and fiscal year 2007 shall be increased by the following amounts:

''(A) For Puerto Rico, $12,000,000 for fiscal year 2006 and $12,000,000 for fiscal year 2007.

''(B) For the Virgin Islands, $2,500,000 for fiscal year 2006 and $5,000,000 for fiscal year 2007.

''(C) For Guam, $2,500,000 for fiscal year 2006 and $5,000,000 for fiscal year 2007.

''(D) For the Northern Mariana Islands, $1,000,000 for fiscal year 2006 and $2,000,000 for fiscal year 2007.

''(E) For American Samoa, $2,000,000 for fiscal year 2006 and $4,000,000 for fiscal year 2007.

Such amounts shall not be taken into account in applying paragraph (2) for fiscal year 2007 but shall be taken into account in applying such paragraph for fiscal year 2008 and subsequent fiscal years.''.

CHAPTER 6—OTHER PROVISIONS

Subchapter A—Family Opportunity Act

SEC. 6061. SHORT TITLE OF SUBCHAPTER.

This subchapter may be cited as the ''Family Opportunity Act of 2005'' or the ''Dylan Lee James Act''.

SEC. 6062. OPPORTUNITY FOR FAMILIES OF DISABLED CHILDREN TO PURCHASE MEDICAID COVERAGE FOR SUCH CHILDREN.

(a) STATE OPTION TO ALLOW FAMILIES OF DISABLED CHILDREN TO PURCHASE MEDICAID COVERAGE FOR SUCH CHILDREN.—

(1) IN GENERAL.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(A) in subsection (a)(10)(A)(ii)—

(i) by striking ''or'' at the end of subclause (XVII);

(ii) by adding ''or'' at the end of subclause (XVIII); and

(iii) by adding at the end the following new subclause:

"(XIX) who are disabled children described in subsection (cc)(1);"; and

(B) by adding at the end the following new subsection:

"(cc)(1) Individuals described in this paragraph are individuals—

"(A) who are children who have not attained 19 years of age and are born—

"(i) on or after January 1, 2001 (or, at the option of a State, on or after an earlier date), in the case of the second, third, and fourth quarters of fiscal year 2007;

"(ii) on or after October 1, 1995 (or, at the option of a State, on or after an earlier date), in the case of each quarter of fiscal year 2008; and

"(iii) after October 1, 1989, in the case of each quarter of fiscal year 2009 and each quarter of any fiscal year thereafter;

"(B) who would be considered disabled under section 1614(a)(3)(C) (as determined under title XVI for children but without regard to any income

or asset eligibility requirements that apply under such title with respect to children); and

''(C) whose family income does not exceed such income level as the State establishes and does not exceed—

''(i) 300 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved; or

''(ii) such higher percent of such poverty line as a State may establish, except that—

''(I) any medical assistance provided to an individual whose family income exceeds 300 percent of such poverty line may only be provided with State funds; and

''(II) no Federal financial participation shall be provided under section 1903(a) for any medical assistance provided to such an individual.''.

(2) INTERACTION WITH EMPLOYER-SPONSORED FAMILY COVERAGE.—Section 1902(cc) of such Act (42 U.S.C. 1396a(cc)), as added by paragraph (1)(B), is amended by adding at the end the following new paragraph:

''(2)(A) If an employer of a parent of an individual described in paragraph (1) offers family coverage under

a group health plan (as defined in section 2791(a) of the Public Health Service Act), the State shall—

''(i) notwithstanding section 1906, require such parent to apply for, enroll in, and pay premiums for such coverage as a condition of such parent's child being or remaining eligible for medical assistance under subsection (a)(10)(A)(ii)(XIX) if the parent is determined eligible for such coverage and the employer contributes at least 50 percent of the total cost of annual premiums for such coverage; and

''(ii) if such coverage is obtained—

''(I) subject to paragraph (2) of section 1916(h), reduce the premium imposed by the State under that section in an amount that reasonably reflects the premium contribution made by the parent for private coverage on behalf of a child with a disability; and

''(II) treat such coverage as a third party liability under subsection (a)(25).

''(B) In the case of a parent to which subparagraph (A) applies, a State, notwithstanding section 1906 but subject to paragraph (1)(C)(ii), may provide for payment of any portion of the annual premium for such family coverage that the parent is required to pay. Any payments made by the State under this subparagraph shall be con-

sidered, for purposes of section 1903(a), to be payments for medical assistance.''.

(b) STATE OPTION TO IMPOSE INCOME-RELATED PREMIUMS.—Section 1916 of such Act (42 U.S.C. 1396o) is amended—

(1) in subsection (a), by striking ''subsection (g)'' and inserting ''subsections (g) and (i)''; and

(2) by adding at the end, as amended by section 6041(b)(2), the following new subsection:

''(i)(1) With respect to disabled children provided medical assistance under section 1902(a)(10)(A)(ii)(XIX), subject to paragraph (2), a State may (in a uniform manner for such children) require the families of such children to pay monthly premiums set on a sliding scale based on family income.

''(2) A premium requirement imposed under paragraph (1) may only apply to the extent that—

''(A) in the case of a disabled child described in that paragraph whose family income—

''(i) does not exceed 200 percent of the poverty line, the aggregate amount of such premium and any premium that the parent is required to pay for family coverage under section 1902(cc)(2)(A)(i) and other cost-sharing

charges do not exceed 5 percent of the family's income; and

''(ii) exceeds 200, but does not exceed 300, percent of the poverty line, the aggregate amount of such premium and any premium that the parent is required to pay for family coverage under section 1902(cc)(2)(A)(i) and other cost-sharing charges do not exceed 7.5 percent of the family's income; and

''(B) the requirement is imposed consistent with section 1902(cc)(2)(A)(ii)(I).

''(3) A State shall not require prepayment of a premium imposed pursuant to paragraph (1) and shall not terminate eligibility of a child under section 1902(a)(10)(A)(ii)(XIX) for medical assistance under this title on the basis of failure to pay any such premium until such failure continues for a period of at least 60 days from the date on which the premium became past due. The State may waive payment of any such premium in any case where the State determines that requiring such payment would create an undue hardship.''.

(c) CONFORMING AMENDMENTS.—(1) Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)) is amended in the matter preceding subparagraph (A), by inserting

''1902(a)(10)(A)(ii)(XIX),'' after ''1902(a)(10)(A)(ii)(XVIII),''.

(2) Section 1905(u)(2)(B) of such Act (42 U.S.C. 1396d(u)(2)(B)) is amended by adding at the end the following sentence: ''Such term excludes any child eligible for medical assistance only by reason of section 1902(a)(10)(A)(ii)(XIX).''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to medical assistance for items and services furnished on or after January 1, 2007.

SEC. 6063. DEMONSTRATION PROJECTS REGARDING HOME AND COMMUNITY-BASED ALTERNATIVES TO PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN.

(a) IN GENERAL.—The Secretary is authorized to conduct, during each of fiscal years 2007 through 2011, demonstration projects (each in the section referred to as a ''demonstration project'') in accordance with this section under which up to 10 States (as defined for purposes of title XIX of the Social Security Act) are awarded grants, on a competitive basis, to test the effectiveness in improving or maintaining a child's functional level and cost-effectiveness of providing coverage of home and community-based alternatives to psychiatric residential treatment for

children enrolled in the Medicaid program under title XIX of such Act.

(b) APPLICATION OF TERMS AND CONDITIONS.—

(1) IN GENERAL.—Subject to the provisions of this section, for the purposes of the demonstration projects, and only with respect to children enrolled under such demonstration projects, a psychiatric residential treatment facility (as defined in section 483.352 of title 42 of the Code of Federal Regulations) shall be deemed to be a facility specified in section 1915(c) of the Social Security Act (42 U.S.C. 1396n(c)), and to be included in each reference in such section 1915(c) to hospitals, nursing facilities, and intermediate care facilities for the mentally retarded.

(2) STATE OPTION TO ASSURE CONTINUITY OF MEDICAID COVERAGE.—Upon the termination of a demonstration project under this section, the State that conducted the project may elect, only with respect to a child who is enrolled in such project on the termination date, to continue to provide medical assistance for coverage of home and community-based alternatives to psychiatric residential treatment for the child in accordance with section 1915(c) of the Social Security Act (42 U.S.C.

1396n(c)), as modified through the application of paragraph (1). Expenditures incurred for providing such medical assistance shall be treated as a home and community-based waiver program under section 1915(c) of the Social Security Act (42 U.S.C. 1396n(c)) for purposes of payment under section 1903 of such Act (42 U.S.C. 1396b).

(c) TERMS OF DEMONSTRATION PROJECTS.—

(1) IN GENERAL.—Except as otherwise provided in this section, a demonstration project shall be subject to the same terms and conditions as apply to a waiver under section 1915(c) of the Social Security Act (42 U.S.C. 1396n(c)), including the waiver of certain requirements under the first sentence of paragraph (3) of such section but not applying the second sentence of such paragraph.

(2) BUDGET NEUTRALITY.—In conducting the demonstration projects under this section, the Secretary shall ensure that the aggregate payments made by the Secretary under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) do not exceed the amount which the Secretary estimates would have been paid under that title if the demonstration projects under this section had not been implemented.

(3) EVALUATION.—The application for a demonstration project shall include an assurance to provide for such interim and final evaluations of the demonstration project by independent third parties, and for such interim and final reports to the Secretary, as the Secretary may require.

(d) PAYMENTS TO STATES; LIMITATIONS TO SCOPE AND FUNDING.—

(1) IN GENERAL.—Subject to paragraph (2), a demonstration project approved by the Secretary under this section shall be treated as a home and community-based waiver program under section 1915(c) of the Social Security Act (42 U.S.C. 1396n(c)) for purposes of payment under section 1903 of such Act (42 U.S.C. 1396b).

(2) LIMITATION.—In no case may the amount of payments made by the Secretary under this section for State demonstration projects for a fiscal year exceed the amount available under subsection (f)(2)(A) for such fiscal year.

(e) SECRETARY'S EVALUATION AND REPORT.—The Secretary shall conduct an interim and final evaluation of State demonstration projects under this section and shall report to the President and Congress the conclusions of

such evaluations within 12 months of completing such evaluations.

(f) FUNDING.—

(1) IN GENERAL.—For the purpose of carrying out this section, there are appropriated, from amounts in the Treasury not otherwise appropriated, for fiscal years 2007 through 2011, a total of $218,000,000, of which—

(A) the amount specified in paragraph (2) shall be available for each of fiscal years 2007 through 2011; and

(B) a total of $1,000,000 shall be available to the Secretary for the evaluations and report under subsection (e).

(2) FISCAL YEAR LIMIT.—

(A) IN GENERAL.—For purposes of paragraph (1), the amount specified in this paragraph for a fiscal year is the amount specified in subparagraph (B) for the fiscal year plus the difference, if any, between the total amount available under this paragraph for prior fiscal years and the total amount previously expended under paragraph (1)(A) for such prior fiscal years.

(B) FISCAL YEAR AMOUNTS.—The amount specified in this subparagraph for—

(i) fiscal year 2007 is $21,000,000;

(ii) fiscal year 2008 is $37,000,000;

(iii) fiscal year 2009 is $49,000,000;

(iv) fiscal year 2010 is $53,000,000; and

(v) fiscal year 2011 is $57,000,000.

SEC. 6064. DEVELOPMENT AND SUPPORT OF FAMILY-TO-FAMILY HEALTH INFORMATION CENTERS.

Section 501 of the Social Security Act (42 U.S.C. 701) is amended by adding at the end the following new subsection:

''(c)(1)(A) For the purpose of enabling the Secretary (through grants, contracts, or otherwise) to provide for special projects of regional and national significance for the development and support of family-to-family health information centers described in paragraph (2)—

''(i) there is appropriated to the Secretary, out of any money in the Treasury not otherwise appropriated—

''(I) $3,000,000 for fiscal year 2007;

''(II) $4,000,000 for fiscal year 2008; and

''(III) $5,000,000 for fiscal year 2009; and

''(ii) there is authorized to be appropriated to the Secretary, $5,000,000 for each of fiscal years 2010 and 2011.

''(B) Funds appropriated or authorized to be appropriated under subparagraph (A) shall—

''(i) be in addition to amounts appropriated under subsection (a) and retained under section 502(a)(1) for the purpose of carrying out activities described in subsection (a)(2); and

''(ii) remain available until expended.

''(2) The family-to-family health information centers described in this paragraph are centers that—

''(A) assist families of children with disabilities or special health care needs to make informed choices about health care in order to promote good treatment decisions, cost-effectiveness, and improved health outcomes for such children;

''(B) provide information regarding the health care needs of, and resources available for, such children;

''(C) identify successful health delivery models for such children;

''(D) develop with representatives of health care providers, managed care organizations, health care purchasers, and appropriate State agencies, a model

for collaboration between families of such children and health professionals;

''(E) provide training and guidance regarding caring for such children;

''(F) conduct outreach activities to the families of such children, health professionals, schools, and other appropriate entities and individuals; and

''(G) are staffed—

''(i) by such families who have expertise in Federal and State public and private health care systems; and

''(ii) by health professionals.

''(3) The Secretary shall develop family-to-family health information centers described in paragraph (2) in accordance with the following:

''(A) With respect to fiscal year 2007, such centers shall be developed in not less than 25 States.

''(B) With respect to fiscal year 2008, such centers shall be developed in not less than 40 States.

''(C) With respect to fiscal year 2009 and each fiscal year thereafter, such centers shall be developed in all States.

''(4) The provisions of this title that are applicable to the funds made available to the Secretary under section

502(a)(1) apply in the same manner to funds made available to the Secretary under paragraph (1)(A).

''(5) For purposes of this subsection, the term 'State' means each of the 50 States and the District of Columbia.''.

SEC. 6065. RESTORATION OF MEDICAID ELIGIBILITY FOR CERTAIN SSI BENEFICIARIES.

(a) IN GENERAL.—Section 1902(a)(10)(A)(i)(II) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(II)) is amended—

(1) by inserting ''(aa)'' after ''(II)'';

(2) by striking '') and'' and inserting ''and'';

(3) by striking ''section or who are'' and inserting ''section), (bb) who are''; and

(4) by inserting before the comma at the end the following: '', or (cc) who are under 21 years of age and with respect to whom supplemental security income benefits would be paid under title XVI if subparagraphs (A) and (B) of section 1611(c)(7) were applied without regard to the phrase 'the first day of the month following' ''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to medical assistance for items and services furnished on or after the date that is 1 year after the date of enactment of this Act.

Subchapter B—Money Follows the Person Rebalancing Demonstration

SEC. 6071. MONEY FOLLOWS THE PERSON REBALANCING DEMONSTRATION.

(a) PROGRAM PURPOSE AND AUTHORITY.—The Secretary is authorized to award, on a competitive basis, grants to States in accordance with this section for demonstration projects (each in this section referred to as an ''MFP demonstration project'') designed to achieve the following objectives with respect to institutional and home and community-based long-term care services under State Medicaid programs:

(1) REBALANCING.—Increase the use of home and community-based, rather than institutional, long-term care services.

(2) MONEY FOLLOWS THE PERSON.—Eliminate barriers or mechanisms, whether in the State law, the State Medicaid plan, the State budget, or otherwise, that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary long-term services in the settings of their choice.

(3) CONTINUITY OF SERVICE.—Increase the ability of the State Medicaid program to assure continued provision of home and community-based long-

term care services to eligible individuals who choose to transition from an institutional to a community setting.

(4) QUALITY ASSURANCE AND QUALITY IMPROVEMENT.—Ensure that procedures are in place (at least comparable to those required under the qualified HCB program) to provide quality assurance for eligible individuals receiving Medicaid home and community-based long-term care services and to provide for continuous quality improvement in such services.

(b) DEFINITIONS.—For purposes of this section:

(1) HOME AND COMMUNITY-BASED LONG-TERM CARE SERVICES.—The term ''home and community-based long-term care services'' means, with respect to a State Medicaid program, home and community-based services (including home health and personal care services) that are provided under the State's qualified HCB program or that could be provided under such a program but are otherwise provided under the Medicaid program.

(2) ELIGIBLE INDIVIDUAL.—The term ''eligible individual'' means, with respect to an MFP demonstration project of a State, an individual in the State—

(A) who, immediately before beginning participation in the MFP demonstration project—

(i) resides (and has resided, for a period of not less than 6 months or for such longer minimum period, not to exceed 2 years, as may be specified by the State) in an inpatient facility;

(ii) is receiving Medicaid benefits for inpatient services furnished by such inpatient facility; and

(iii) with respect to whom a determination has been made that, but for the provision of home and community-based long-term care services, the individual would continue to require the level of care provided in an inpatient facility and, in any case in which the State applies a more stringent level of care standard as a result of implementing the State plan option permitted under section 1915(i) of the Social Security Act, the individual must continue to require at least the level of care which had resulted in admission to the institution; and

(B) who resides in a qualified residence beginning on the initial date of participation in the demonstration project.

(3) INPATIENT FACILITY.—The term ''inpatient facility'' means a hospital, nursing facility, or intermediate care facility for the mentally retarded. Such term includes an institution for mental diseases, but only, with respect to a State, to the extent medical assistance is available under the State Medicaid plan for services provided by such institution.

(4) MEDICAID.—The term ''Medicaid'' means, with respect to a State, the State program under title XIX of the Social Security Act (including any waiver or demonstration under such title or under section 1115 of such Act relating to such title).

(5) QUALIFIED HCB PROGRAM.—The term ''qualified HCB program'' means a program providing home and community-based long-term care services operating under Medicaid, whether or not operating under waiver authority.

(6) QUALIFIED RESIDENCE.—The term ''qualified residence'' means, with respect to an eligible individual—

(A) a home owned or leased by the individual or the individual's family member;

(B) an apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control; and

(C) a residence, in a community-based residential setting, in which no more than 4 unrelated individuals reside.

(7) QUALIFIED EXPENDITURES.—The term ''qualified expenditures'' means expenditures by the State under its MFP demonstration project for home and community-based long-term care services for an eligible individual participating in the MFP demonstration project, but only with respect to services furnished during the 12-month period beginning on the date the individual is discharged from an inpatient facility referred to in paragraph (2)(A)(i).

(8) SELF-DIRECTED SERVICES.—The term ''self-directed'' means, with respect to home and community-based long-term care services for an eligible individual, such services for the individual which are planned and purchased under the direction and control of such individual or the individual's authorized representative (as defined by the Secretary), including the amount, duration, scope,

provider, and location of such services, under the State Medicaid program consistent with the following requirements:

(A) ASSESSMENT.—There is an assessment of the needs, capabilities, and preferences of the individual with respect to such services.

(B) SERVICE PLAN.—Based on such assessment, there is developed jointly with such individual or the individual's authorized representative a plan for such services for such individual that is approved by the State and that—

(i) specifies those services, if any, which the individual or the individual's authorized representative would be responsible for directing;

(ii) identifies the methods by which the individual or the individual's authorized representative or an agency designated by an individual or representative will select, manage, and dismiss providers of such services;

(iii) specifies the role of family members and others whose participation is sought by the individual or the individual's

authorized representative with respect to such services;

(iv) is developed through a person-centered process that—

(I) is directed by the individual or the individual's authorized representative;

(II) builds upon the individual's capacity to engage in activities that promote community life and that respects the individual's preferences, choices, and abilities; and

(III) involves families, friends, and professionals as desired or required by the individual or the individual's authorized representative;

(v) includes appropriate risk management techniques that recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of such plan based upon the resources and capabilities of the individual or the individual's authorized representative; and

(vi) may include an individualized budget which identifies the dollar value of the services and supports under the control and direction of the individual or the individual's authorized representative.

(C) BUDGET PROCESS.—With respect to individualized budgets described in subparagraph (B)(vi), the State application under subsection (c)—

(i) describes the method for calculating the dollar values in such budgets based on reliable costs and service utilization;

(ii) defines a process for making adjustments in such dollar values to reflect changes in individual assessments and service plans; and

(iii) provides a procedure to evaluate expenditures under such budgets.

(9) STATE.—The term ''State'' has the meaning given such term for purposes of title XIX of the Social Security Act.

(c) STATE APPLICATION.—A State seeking approval of an MFP demonstration project shall submit to the Secretary, at such time and in such format as the Secretary

requires, an application meeting the following requirements and containing such additional information, provisions, and assurances, as the Secretary may require:

(1) ASSURANCE OF A PUBLIC DEVELOPMENT PROCESS.—The application contains an assurance that the State has engaged, and will continue to engage, in a public process for the design, development, and evaluation of the MFP demonstration project that allows for input from eligible individuals, the families of such individuals, authorized representatives of such individuals, providers, and other interested parties.

(2) OPERATION IN CONNECTION WITH QUALIFIED HCB PROGRAM TO ASSURE CONTINUITY OF SERVICES.—The State will conduct the MFP demonstration project for eligible individuals in conjunction with the operation of a qualified HCB program that is in operation (or approved) in the State for such individuals in a manner that assures continuity of Medicaid coverage for such individuals so long as such individuals continue to be eligible for medical assistance.

(3) DEMONSTRATION PROJECT PERIOD.—The application shall specify the period of the MFP demonstration project, which shall include at least 2 con-

secutive fiscal years in the 5-fiscal-year period beginning with fiscal year 2007.

(4) SERVICE AREA.—The application shall specify the service area or areas of the MFP demonstration project, which may be a statewide area or 1 or more geographic areas of the State.

(5) TARGETED GROUPS AND NUMBERS OF INDIVIDUALS SERVED.—The application shall specify—

(A) the target groups of eligible individuals to be assisted to transition from an inpatient facility to a qualified residence during each fiscal year of the MFP demonstration project;

(B) the projected numbers of eligible individuals in each targeted group of eligible individuals to be so assisted during each such year; and

(C) the estimated total annual qualified expenditures for each fiscal year of the MFP demonstration project.

(6) INDIVIDUAL CHOICE, CONTINUITY OF CARE.—The application shall contain assurances that—

(A) each eligible individual or the individual's authorized representative will be provided the opportunity to make an informed choice re-

garding whether to participate in the MFP demonstration project;

(B) each eligible individual or the individual's authorized representative will choose the qualified residence in which the individual will reside and the setting in which the individual will receive home and community-based long-term care services;

(C) the State will continue to make available, so long as the State operates its qualified HCB program consistent with applicable requirements, home and community-based long-term care services to each individual who completes participation in the MFP demonstration project for as long as the individual remains eligible for medical assistance for such services under such qualified HCB program (including meeting a requirement relating to requiring a level of care provided in an inpatient facility and continuing to require such services, and, if the State applies a more stringent level of care standard as a result of implementing the State plan option permitted under section 1915(i) of the Social Security Act, meeting the requirement for at least the level of care which had re-

sulted in the individual's admission to the institution).

(7) REBALANCING.—The application shall—

(A) provide such information as the Secretary may require concerning the dollar amounts of State Medicaid expenditures for the fiscal year, immediately preceding the first fiscal year of the State's MFP demonstration project, for long-term care services and the percentage of such expenditures that were for institutional long-term care services or were for home and community-based long-term care services;

(B)(i) specify the methods to be used by the State to increase, for each fiscal year during the MFP demonstration project, the dollar amount of such total expenditures for home and community-based long-term care services and the percentage of such total expenditures for long-term care services that are for home and community-based long-term care services; and

(ii) describe the extent to which the MFP demonstration project will contribute to accomplishment of objectives described in subsection (a).

(8) MONEY FOLLOWS THE PERSON.—The application shall describe the methods to be used by the State to eliminate any legal, budgetary, or other barriers to flexibility in the availability of Medicaid funds to pay for long-term care services for eligible individuals participating in the project in the appropriate settings of their choice, including costs to transition from an institutional setting to a qualified residence.

(9) MAINTENANCE OF EFFORT AND COST-EFFECTIVENESS.—The application shall contain or be accompanied by such information and assurances as may be required to satisfy the Secretary that—

(A) total expenditures under the State Medicaid program for home and community-based long-term care services will not be less for any fiscal year during the MFP demonstration project than for the greater of such expenditures for—

(i) fiscal year 2005; or

(ii) any succeeding fiscal year before the first year of the MFP demonstration project; and

(B) in the case of a qualified HCB program operating under a waiver under sub-

section (c) or (d) of section 1915 of the Social Security Act (42 U.S.C. 1396n), but for the amount awarded under a grant under this section, the State program would continue to meet the cost-effectiveness requirements of subsection (c)(2)(D) of such section or comparable requirements under subsection (d)(5) of such section, respectively.

(10) WAIVER REQUESTS.—The application shall contain or be accompanied by requests for any modification or adjustment of waivers of Medicaid requirements described in subsection (d)(3), including adjustments to the maximum numbers of individuals included and package of benefits, including one-time transitional services, provided.

(11) QUALITY ASSURANCE AND QUALITY IMPROVEMENT.—The application shall include—

(A) a plan satisfactory to the Secretary for quality assurance and quality improvement for home and community-based long-term care services under the State Medicaid program, including a plan to assure the health and welfare of individuals participating in the MFP demonstration project; and

(B) an assurance that the State will cooperate in carrying out activities under subsection (f) to develop and implement continuous quality assurance and quality improvement systems for home and community-based long-term care services.

(12) OPTIONAL PROGRAM FOR SELF-DIRECTED SERVICES.—If the State elects to provide for any home and community-based long-term care services as self-directed services (as defined in subsection (b)(8)) under the MFP demonstration project, the application shall provide the following:

(A) MEETING REQUIREMENTS.—A description of how the project will meet the applicable requirements of such subsection for the provision of self-directed services.

(B) VOLUNTARY ELECTION.—A description of how eligible individuals will be provided with the opportunity to make an informed election to receive self-directed services under the project and after the end of the project.

(C) STATE SUPPORT IN SERVICE PLAN DEVELOPMENT.—Satisfactory assurances that the State will provide support to eligible individuals

who self-direct in developing and implementing their service plans.

(D) OVERSIGHT OF RECEIPT OF SERVICES.—Satisfactory assurances that the State will provide oversight of eligible individual's receipt of such self-directed services, including steps to assure the quality of services provided and that the provision of such services are consistent with the service plan under such subsection.

Nothing in this section shall be construed as requiring a State to make an election under the project to provide for home and community-based long-term care services as self-directed services, or as requiring an individual to elect to receive self-directed services under the project.

(13) REPORTS AND EVALUATION.—The application shall provide that—

(A) the State will furnish to the Secretary such reports concerning the MFP demonstration project, on such timetable, in such uniform format, and containing such information as the Secretary may require, as will allow for reliable comparisons of MFP demonstration projects across States; and

(B) the State will participate in and cooperate with the evaluation of the MFP demonstration project.

(d) SECRETARY'S AWARD OF COMPETITIVE GRANTS.—

(1) IN GENERAL.—The Secretary shall award grants under this section on a competitive basis to States selected from among those with applications meeting the requirements of subsection (c), in accordance with the provisions of this subsection.

(2) SELECTION AND MODIFICATION OF STATE APPLICATIONS.—In selecting State applications for the awarding of such a grant, the Secretary—

(A) shall take into consideration the manner in which, and extent to which, the State proposes to achieve the objectives specified in subsection (a);

(B) shall seek to achieve an appropriate national balance in the numbers of eligible individuals, within different target groups of eligible individuals, who are assisted to transition to qualified residences under MFP demonstration projects, and in the geographic distribution of States operating MFP demonstration projects;

(C) shall give preference to State applications proposing—

(i) to provide transition assistance to eligible individuals within multiple target groups; and

(ii) to provide eligible individuals with the opportunity to receive home and community-based long-term care services as self-directed services, as defined in subsection (b)(8); and

(D) shall take such objectives into consideration in setting the annual amounts of State grant awards under this section.

(3) WAIVER AUTHORITY.—The Secretary is authorized to waive the following provisions of title XIX of the Social Security Act, to the extent necessary to enable a State initiative to meet the requirements and accomplish the purposes of this section:

(A) STATEWIDENESS.—Section 1902(a)(1), in order to permit implementation of a State initiative in a selected area or areas of the State.

(B) COMPARABILITY.—Section 1902(a)(10)(B), in order to permit a State ini-

tiative to assist a selected category or categories of individuals described in subsection (b)(2)(A).

(C) INCOME AND RESOURCES ELIGIBILITY.—Section 1902(a)(10)(C)(i)(III), in order to permit a State to apply institutional eligibility rules to individuals transitioning to community-based care.

(D) PROVIDER AGREEMENTS.—Section 1902(a)(27), in order to permit a State to implement self-directed services in a cost-effective manner.

(4) CONDITIONAL APPROVAL OF OUTYEAR GRANT.—In awarding grants under this section, the Secretary shall condition the grant for the second and any subsequent fiscal years of the grant period on the following:

(A) NUMERICAL BENCHMARKS.—The State must demonstrate to the satisfaction of the Secretary that it is meeting numerical benchmarks specified in the grant agreement for—

(i) increasing State Medicaid support for home and community-based long-term care services under subsection (c)(5); and

(ii) numbers of eligible individuals assisted to transition to qualified residences.

(B) QUALITY OF CARE.—The State must demonstrate to the satisfaction of the Secretary that it is meeting the requirements under subsection (c)(11) to assure the health and welfare of MFP demonstration project participants.

(e) PAYMENTS TO STATES; CARRYOVER OF UNUSED GRANT AMOUNTS.—

(1) PAYMENTS.—For each calendar quarter in a fiscal year during the period a State is awarded a grant under subsection (d), the Secretary shall pay to the State from its grant award for such fiscal year an amount equal to the lesser of—

(A) the MFP-enhanced FMAP (as defined in paragraph (5)) of the amount of qualified expenditures made during such quarter; or

(B) the total amount remaining in such grant award for such fiscal year (taking into account the application of paragraph (2)).

(2) CARRYOVER OF UNUSED AMOUNTS.—Any portion of a State grant award for a fiscal year under this section remaining at the end of such fiscal year shall remain available to the State for the next 4 fiscal years, subject to paragraph (3).

(3) REAWARDING OF CERTAIN UNUSED AMOUNTS.—In the case of a State that the Secretary determines pursuant to subsection (d)(4) has failed to meet the conditions for continuation of a MFP demonstration project under this section in a succeeding year or years, the Secretary shall rescind the grant awards for such succeeding year or years, together with any unspent portion of an award for prior years, and shall add such amounts to the appropriation for the immediately succeeding fiscal year for grants under this section.

(4) PREVENTING DUPLICATION OF PAYMENT.—The payment under a MFP demonstration project with respect to qualified expenditures shall be in lieu of any payment with respect to such expenditures that could otherwise be paid under Medicaid, including under section 1903(a) of the Social Security Act. Nothing in the previous sentence shall be construed as preventing the payment under Medicaid for such expenditures in a grant year after amounts available to pay for such expenditures under the MFP demonstration project have been exhausted.

(5) MFP-ENHANCED FMAP.—For purposes of paragraph (1)(A), the ''MFP-enhanced FMAP'', for a State for a fiscal year, is equal to the Federal

medical assistance percentage (as defined in the first sentence of section 1905(b)) for the State increased by a number of percentage points equal to 50 percent of the number of percentage points by which (A) such Federal medical assistance percentage for the State, is less than (B) 100 percent; but in no case shall the MFP-enhanced FMAP for a State exceed 90 percent.

(f) QUALITY ASSURANCE AND IMPROVEMENT; TECHNICAL ASSISTANCE; OVERSIGHT.—

(1) IN GENERAL.—The Secretary, either directly or by grant or contract, shall provide for technical assistance to, and oversight of, States for purposes of upgrading quality assurance and quality improvement systems under Medicaid home and community-based waivers, including—

(A) dissemination of information on promising practices;

(B) guidance on system design elements addressing the unique needs of participating beneficiaries;

(C) ongoing consultation on quality, including assistance in developing necessary tools, resources, and monitoring systems; and

(D) guidance on remedying programmatic and systemic problems.

(2) FUNDING.—From the amounts appropriated under subsection (h)(1) for the portion of fiscal year 2007 that begins on January 1, 2007, and ends on September 30, 2007, and for fiscal year 2008, not more than $2,400,000 shall be available to the Secretary to carry out this subsection during the period that begins on January 1, 2007, and ends on September 30, 2011.

(g) RESEARCH AND EVALUATION.—

(1) IN GENERAL.—The Secretary, directly or through grant or contract, shall provide for research on, and a national evaluation of, the program under this section, including assistance to the Secretary in preparing the final report required under paragraph (2). The evaluation shall include an analysis of projected and actual savings related to the transition of individuals to qualified residences in each State conducting an MFP demonstration project.

(2) FINAL REPORT.—The Secretary shall make a final report to the President and Congress, not later than September 30, 2011, reflecting the evaluation described in paragraph (1) and providing

findings and conclusions on the conduct and effectiveness of MFP demonstration projects.

(3) FUNDING.—From the amounts appropriated under subsection (h)(1) for each of fiscal years 2008 through 2011, not more than $1,100,000 per year shall be available to the Secretary to carry out this subsection.

(h) APPROPRIATIONS.—

(1) IN GENERAL.—There are appropriated, from any funds in the Treasury not otherwise appropriated, for grants to carry out this section—

(A) $250,000,000 for the portion of fiscal year 2007 beginning on January 1, 2007, and ending on September 30, 2007;

(B) $300,000,000 for fiscal year 2008;

(C) $350,000,000 for fiscal year 2009;

(D) $400,000,000 for fiscal year 2010; and

(E) $450,000,000 for fiscal year 2011.

(2) AVAILABILITY.—Amounts made available under paragraph (1) for a fiscal year shall remain available for the awarding of grants to States by not later than September 30, 2011.

Subchapter C—Miscellaneous

SEC. 6081. MEDICAID TRANSFORMATION GRANTS.

(a) IN GENERAL.—Section 1903 of the Social Security Act (42 U.S.C. 1396b), as amended by sections 6037(a)(2) and 6043(b), is amended by adding at the end the following new subsection:

''(z) MEDICAID TRANSFORMATION PAYMENTS.—

''(1) IN GENERAL.—In addition to the payments provided under subsection (a), subject to paragraph (4), the Secretary shall provide for payments to States for the adoption of innovative methods to improve the effectiveness and efficiency in providing medical assistance under this title.

''(2) PERMISSIBLE USES OF FUNDS.—The following are examples of innovative methods for which funds provided under this subsection may be used:

''(A) Methods for reducing patient error rates through the implementation and use of electronic health records, electronic clinical decision support tools, or e-prescribing programs.

''(B) Methods for improving rates of collection from estates of amounts owed under this title.

''(C) Methods for reducing waste, fraud, and abuse under the program under this title,

such as reducing improper payment rates as measured by annual payment error rate measurement (PERM) project rates.

''(D) Implementation of a medication risk management program as part of a drug use review program under section 1927(g).

''(E) Methods in reducing, in clinically appropriate ways, expenditures under this title for covered outpatient drugs, particularly in the categories of greatest drug utilization, by increasing the utilization of generic drugs through the use of education programs and other incentives to promote greater use of generic drugs.

''(F) Methods for improving access to primary and specialty physician care for the uninsured using integrated university-based hospital and clinic systems.

''(3) APPLICATION; TERMS AND CONDITIONS.—

''(A) IN GENERAL.—No payments shall be made to a State under this subsection unless the State applies to the Secretary for such payments in a form, manner, and time specified by the Secretary.

''(B) TERMS AND CONDITIONS.—Such payments are made under such terms and conditions consistent with this subsection as the Secretary prescribes.

''(C) ANNUAL REPORT.—Payment to a State under this subsection is conditioned on the State submitting to the Secretary an annual report on the programs supported by such payment. Such report shall include information on—

''(i) the specific uses of such payment;

''(ii) an assessment of quality improvements and clinical outcomes under such programs; and

''(iii) estimates of cost savings resulting from such programs.

''(4) FUNDING.—

''(A) LIMITATION ON FUNDS.—The total amount of payments under this subsection shall be equal to, and shall not exceed—

''(i) $75,000,000 for fiscal year 2007; and

''(ii) $75,000,000 for fiscal year 2008.

This subsection constitutes budget authority in advance of appropriations Acts and represents

the obligation of the Secretary to provide for the payment of amounts provided under this subsection.

''(B) ALLOCATION OF FUNDS.—The Secretary shall specify a method for allocating the funds made available under this subsection among States. Such method shall provide preference for States that design programs that target health providers that treat significant numbers of Medicaid beneficiaries. Such method shall provide that not less than 25 percent of such funds shall be allocated among States the population of which (as determined according to data collected by the United States Census Bureau) as of July 1, 2004, was more than 105 percent of the population of the respective State (as so determined) as of April 1, 2000.

''(C) FORM AND MANNER OF PAYMENT.—Payment to a State under this subsection shall be made in the same manner as other payments under section 1903(a). There is no requirement for State matching funds to receive payments under this subsection.

''(5) MEDICATION RISK MANAGEMENT PROGRAM.—

''(A) IN GENERAL.—For purposes of this subsection, the term 'medication risk management program' means a program for targeted beneficiaries that ensures that covered outpatient drugs are appropriately used to optimize therapeutic outcomes through improved medication use and to reduce the risk of adverse events.

''(B) ELEMENTS.—Such program may include the following elements:

''(i) The use of established principles and standards for drug utilization review and best practices to analyze prescription drug claims of targeted beneficiaries and identify outlier physicians.

''(ii) On an ongoing basis provide outlier physicians—

''(I) a comprehensive pharmacy claims history for each targeted beneficiary under their care;

''(II) information regarding the frequency and cost of relapses and hospitalizations of targeted beneficiaries under the physician's care; and

"(III) applicable best practice guidelines and empirical references.

"(iii) Monitor outlier physician's prescribing, such as failure to refill, dosage strengths, and provide incentives and information to encourage the adoption of best clinical practices.

"(C) TARGETED BENEFICIARIES.—For purposes of this paragraph, the term 'targeted beneficiaries' means Medicaid eligible beneficiaries who are identified as having high prescription drug costs and medical costs, such as individuals with behavioral disorders or multiple chronic diseases who are taking multiple medications.".

SEC. 6082. HEALTH OPPORTUNITY ACCOUNTS.

Title XIX of the Social Security Act, as amended by sections 6035 and 6044, is amended—

(1) by redesignating section 1938 as section 1939; and

(2) by inserting after section 1937 the following new section:

"HEALTH OPPORTUNITY ACCOUNTS

"SEC. 1938. (a) AUTHORITY.—

"(1) IN GENERAL.—Notwithstanding any other provision of this title, the Secretary shall establish a

demonstration program under which States may provide under their State plans under this title (including such a plan operating under a statewide waiver under section 1115) in accordance with this section for the provision of alternative benefits consistent with subsection (c) for eligible population groups in one or more geographic areas of the State specified by the State. An amendment under the previous sentence is referred to in this section as a 'State demonstration program'.

''(2) INITIAL DEMONSTRATION.—

''(A) IN GENERAL.—The demonstration program under this section shall begin on January 1, 2007. During the first 5 years of such program, the Secretary shall not approve more than 10 States to conduct demonstration programs under this section, with each State demonstration program covering 1 or more geographic areas specified by the State. After such 5-year period—

''(i) unless the Secretary finds, taking into account cost-effectiveness, quality of care, and other criteria that the Secretary specifies, that a State demonstration program previously implemented has been un-

successful, such a demonstration program may be extended or made permanent in the State; and

''(ii) unless the Secretary finds, taking into account cost-effectiveness, quality of care, and other criteria that the Secretary specifies, that all State demonstration programs previously implemented were unsuccessful, other States may implement State demonstration programs.

''(B) GAO REPORT.—

''(i) IN GENERAL.—Not later than 3 months after the end of the 5-year period described in subparagraph (A), the Comptroller General of the United States shall submit a report to Congress evaluating the demonstration programs conducted under this section during such period.

''(ii) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Comptroller General of the United States, $550,000 for the period of fiscal years 2007 through 2010 to carry out clause (i).

''(3) APPROVAL.—The Secretary shall not approve a State demonstration program under paragraph (1) unless the program includes the following:

''(A) Creating patient awareness of the high cost of medical care.

''(B) Providing incentives to patients to seek preventive care services.

''(C) Reducing inappropriate use of health care services.

''(D) Enabling patients to take responsibility for health outcomes.

''(E) Providing enrollment counselors and ongoing education activities.

''(F) Providing transactions involving health opportunity accounts to be conducted electronically and without cash.

''(G) Providing access to negotiated provider payment rates consistent with this section.

Nothing in this section shall be construed as preventing a State demonstration program from providing incentives for patients obtaining appropriate preventive care (as defined for purposes of section 223(c)(2)(C) of the Internal Revenue Code of 1986), such as additional account contributions for an individual demonstrating healthy prevention practices.

''(4) NO REQUIREMENT FOR STATEWIDENESS.—Nothing in this section or any other provision of law shall be construed to require that a State must provide for the implementation of a State demonstration program on a Statewide basis.

''(b) ELIGIBLE POPULATION GROUPS.—

''(1) IN GENERAL.—A State demonstration program under this section shall specify the eligible population groups consistent with paragraphs (2) and (3).

''(2) ELIGIBILITY LIMITATIONS DURING INITIAL DEMONSTRATION PERIOD.—During the initial 5 years of the demonstration program under this section, a State demonstration program shall not apply to any of the following individuals:

''(A) Individuals who are 65 years of age or older.

''(B) Individuals who are disabled, regardless of whether or not their eligibility for medical assistance under this title is based on such disability.

''(C) Individuals who are eligible for medical assistance under this title only because they

are (or were within the previous 60 days) pregnant.

''(D) Individuals who have been eligible for medical assistance for a continuous period of less than 3 months.

''(3) ADDITIONAL LIMITATIONS.—A State demonstration program shall not apply to any individual within a category of individuals described in section 1937(a)(2)(B).

''(4) LIMITATIONS.—

''(A) STATE OPTION.—This subsection shall not be construed as preventing a State from further limiting eligibility.

''(B) ON ENROLLEES IN MEDICAID MANAGED CARE ORGANIZATIONS.—Insofar as the State provides for eligibility of individuals who are enrolled in medicaid managed care organizations, such individuals may participate in the State demonstration program only if the State provides assurances satisfactory to the Secretary that the following conditions are met with respect to any such organization:

''(i) In no case may the number of such individuals enrolled in the organization who participate in the program exceed

5 percent of the total number of individuals enrolled in such organization.

''(ii) The proportion of enrollees in the organization who so participate is not significantly disproportionate to the proportion of such enrollees in other such organizations who participate.

''(iii) The State has provided for an appropriate adjustment in the per capita payments to the organization to account for such participation, taking into account differences in the likely use of health services between enrollees who so participate and enrollees who do not so participate.

''(5) VOLUNTARY PARTICIPATION.—An eligible individual shall be enrolled in a State demonstration program only if the individual voluntarily enrolls. Except in such hardship cases as the Secretary shall specify, such an enrollment shall be effective for a period of 12 months, but may be extended for additional periods of 12 months each with the consent of the individual.

''(6) 1-YEAR MORATORIUM FOR REENROLLMENT.—An eligible individual who, for any reason, is disenrolled from a State demonstration program

conducted under this section shall not be permitted to reenroll in such program before the end of the 1-year period that begins on the effective date of such disenrollment.

''(e) ALTERNATIVE BENEFITS.—

''(1) IN GENERAL.—The alternative benefits provided under this section shall consist, consistent with this subsection, of at least—

''(A) coverage for medical expenses in a year for items and services for which benefits are otherwise provided under this title after an annual deductible described in paragraph (2) has been met; and

''(B) contribution into a health opportunity account.

Nothing in subparagraph (A) shall be construed as preventing a State from providing for coverage of preventive care (referred to in subsection (a)(3)) within the alternative benefits without regard to the annual deductible.

''(2) ANNUAL DEDUCTIBLE.—The amount of the annual deductible described in paragraph (1)(A) shall be at least 100 percent, but no more than 110 percent, of the annualized amount of contributions to the health opportunity account under subsection

(d)(2)(A)(i), determined without regard to any limitation described in subsection (d)(2)(C)(i)(II).

''(3) ACCESS TO NEGOTIATED PROVIDER PAYMENT RATES.—

''(A) FEE-FOR-SERVICE ENROLLEES.—In the case of an individual who is participating in a State demonstration program and who is not enrolled with a medicaid managed care organization, the State shall provide that the individual may obtain demonstration program medicaid services from—

''(i) any participating provider under this title at the same payment rates that would be applicable to such services if the deductible described in paragraph (1)(A) was not applicable; or

''(ii) any other provider at payment rates that do not exceed 125 percent of the payment rate that would be applicable to such services furnished by a participating provider under this title if the deductible described in paragraph (1)(A) was not applicable.

''(B) TREATMENT UNDER MEDICAID MANAGED CARE PLANS.—In the case of an indi-

vidual who is participating in a State demonstration program and is enrolled with a medicaid managed care organization, the State shall enter into an arrangement with the organization under which the individual may obtain demonstration program medicaid services from any provider described in clause (ii) of subparagraph (A) at payment rates that do not exceed the payment rates that may be imposed under that clause.

''(C) COMPUTATION.—The payment rates described in subparagraphs (A) and (B) shall be computed without regard to any cost sharing that would be otherwise applicable under sections 1916 and 1916A.

''(D) DEFINITIONS.—For purposes of this paragraph:

''(i) The term 'demonstration program medicaid services' means, with respect to an individual participating in a State demonstration program, services for which the individual would be provided medical assistance under this title but for the application of the deductible described in paragraph (1)(A).

"(ii) The term 'participating provider' means—

"(I) with respect to an individual described in subparagraph (A), a health care provider that has entered into a participation agreement with the State for the provision of services to individuals entitled to benefits under the State plan; or

"(II) with respect to an individual described in subparagraph (B) who is enrolled in a medicaid managed care organization, a health care provider that has entered into an arrangement for the provision of services to enrollees of the organization under this title.

"(4) NO EFFECT ON SUBSEQUENT BENEFITS.—Except as provided under paragraphs (1) and (2), alternative benefits for an eligible individual shall consist of the benefits otherwise provided to the individual, including cost sharing relating to such benefits.

"(5) OVERRIDING COST SHARING AND COMPARABILITY REQUIREMENTS FOR ALTERNATIVE

BENEFITS.—The provisions of this title relating to cost sharing for benefits (including sections 1916 and 1916A) shall not apply with respect to benefits to which the annual deductible under paragraph (1)(A) applies. The provisions of section 1902(a)(10)(B) (relating to comparability) shall not apply with respect to the provision of alternative benefits (as described in this subsection).

''(6) TREATMENT AS MEDICAL ASSISTANCE.—Subject to subparagraphs (D) and (E) of subsection (d)(2), payments for alternative benefits under this section (including contributions into a health opportunity account) shall be treated as medical assistance for purposes of section 1903(a).

''(7) USE OF TIERED DEDUCTIBLE AND COST SHARING.—

''(A) IN GENERAL.—A State—

''(i) may vary the amount of the annual deductible applied under paragraph (1)(A) based on the income of the family involved so long as it does not favor families with higher income over those with lower income; and

''(ii) may vary the amount of the maximum out-of-pocket cost sharing (as de-

fined in subparagraph (B)) based on the income of the family involved so long as it does not favor families with higher income over those with lower income.

''(B) MAXIMUM OUT-OF-POCKET COST SHARING.—For purposes of subparagraph (A)(ii), the term 'maximum out-of-pocket cost sharing' means, for an individual or family, the amount by which the annual deductible level applied under paragraph (1)(A) to the individual or family exceeds the balance in the health opportunity account for the individual or family.

''(8) CONTRIBUTIONS BY EMPLOYERS.—Nothing in this section shall be construed as preventing an employer from providing health benefits coverage consisting of the coverage described in paragraph (1)(A) to individuals who are provided alternative benefits under this section.

''(d) HEALTH OPPORTUNITY ACCOUNT.—

''(1) IN GENERAL.—For purposes of this section, the term 'health opportunity account' means an account that meets the requirements of this subsection.

''(2) CONTRIBUTIONS.—

"(A) IN GENERAL.—No contribution may be made into a health opportunity account except—

"(i) contributions by the State under this title; and

"(ii) contributions by other persons and entities, such as charitable organizations, as permitted under section 1903(w).

"(B) STATE CONTRIBUTION.—A State shall specify the contribution amount that shall be deposited under subparagraph (A)(i) into a health opportunity account.

"(C) LIMITATION ON ANNUAL STATE CONTRIBUTION PROVIDED AND PERMITTING IMPOSITION OF MAXIMUM ACCOUNT BALANCE.—

"(i) IN GENERAL.—A State—

"(I) may impose limitations on the maximum contributions that may be deposited under subparagraph (A)(i) into a health opportunity account in a year;

"(II) may limit contributions into such an account once the balance in the account reaches a level specified by the State; and

"(III) subject to clauses (ii) and (iii) and subparagraph (D)(i), may not provide contributions described in subparagraph (A)(i) to a health opportunity account on behalf of an individual or family to the extent the amount of such contributions (including both State and Federal shares) exceeds, on an annual basis, $2,500 for each individual (or family member) who is an adult and $1,000 for each individual (or family member) who is a child.

"(ii) INDEXING OF DOLLAR LIMITATIONS.—For each year after 2006, the dollar amounts specified in clause (i)(III) shall be annually increased by the Secretary by a percentage that reflects the annual percentage increase in the medical care component of the consumer price index for all urban consumers.

"(iii) BUDGET NEUTRAL ADJUSTMENT.—A State may provide for dollar limitations in excess of those specified in clause (i)(III) (as increased under clause

(ii)) for specified individuals if the State provides assurances satisfactory to the Secretary that contributions otherwise made to other individuals will be reduced in a manner so as to provide for aggregate contributions that do not exceed the aggregate contributions that would otherwise be permitted under this subparagraph.

''(D) LIMITATIONS ON FEDERAL MATCHING.—

''(i) STATE CONTRIBUTION.—A State may contribute under subparagraph (A)(i) amounts to a health opportunity account in excess of the limitations provided under subparagraph (C)(i)(III), but no Federal financial participation shall be provided under section 1903(a) with respect to contributions in excess of such limitations.

''(ii) NO FFP FOR PRIVATE CONTRIBUTIONS.—No Federal financial participation shall be provided under section 1903(a) with respect to any contributions described in subparagraph (A)(ii) to a health opportunity account.

''(E) APPLICATION OF DIFFERENT MATCHING RATES.—The Secretary shall provide a method under which, for expenditures made from a health opportunity account for medical care for which the Federal matching rate under section 1903(a) exceeds the Federal medical assistance percentage, a State may obtain payment under such section at such higher matching rate for such expenditures.

''(3) USE.—

''(A) GENERAL USES.—

''(i) IN GENERAL.—Subject to the succeeding provisions of this paragraph, amounts in a health opportunity account may be used for payment of such health care expenditures as the State specifies.

''(ii) GENERAL LIMITATION.—Subject to subparagraph (B)(ii), in no case shall such account be used for payment for health care expenditures that are not payment of medical care (as defined by section 213(d) of the Internal Revenue Code of 1986).

''(iii) STATE RESTRICTIONS.—In applying clause (i), a State may restrict payment for—

''(I) providers of items and services to providers that are licensed or otherwise authorized under State law to provide the item or service and may deny payment for such a provider on the basis that the provider has been found, whether with respect to this title or any other health benefit program, to have failed to meet quality standards or to have committed 1 or more acts of fraud or abuse; and

''(II) items and services insofar as the State finds they are not medically appropriate or necessary.

''(iv) ELECTRONIC WITHDRAWALS.—The State demonstration program shall provide for a method whereby withdrawals may be made from the account for such purposes using an electronic system and shall not permit withdrawals from the account in cash.

"(B) MAINTENANCE OF HEALTH OPPORTUNITY ACCOUNT AFTER BECOMING INELIGIBLE FOR PUBLIC BENEFIT.—

"(i) IN GENERAL.—Notwithstanding any other provision of law, if an account holder of a health opportunity account becomes ineligible for benefits under this title because of an increase in income or assets—

"(I) no additional contribution shall be made into the account under paragraph (2)(A)(i);

"(II) subject to clause (iii), the balance in the account shall be reduced by 25 percent; and

"(III) subject to the succeeding provisions of this subparagraph, the account shall remain available to the account holder for 3 years after the date on which the individual becomes ineligible for such benefits for withdrawals under the same terms and conditions as if the account holder remained eligible for such benefits, and such withdrawals shall be treated as

medical assistance in accordance with subsection (c)(6).

''(ii) SPECIAL RULES.—Withdrawals under this subparagraph from an account—

''(I) shall be available for the purchase of health insurance coverage; and

''(II) may, subject to clause (iv), be made available (at the option of the State) for such additional expenditures (such as job training and tuition expenses) specified by the State (and approved by the Secretary) as the State may specify.

''(iii) EXCEPTION FROM 25 PERCENT SAVINGS TO GOVERNMENT FOR PRIVATE CONTRIBUTIONS.—Clause (i)(II) shall not apply to the portion of the account that is attributable to contributions described in paragraph (2)(A)(ii). For purposes of accounting for such contributions, withdrawals from a health opportunity account shall first be attributed to contributions described in paragraph (2)(A)(i).

''(iv) CONDITION FOR NON-HEALTH WITHDRAWALS.—No withdrawal may be made from an account under clause (ii)(II) unless the accountholder has participated in the program under this section for at least 1 year.

''(v) NO REQUIREMENT FOR CONTINUATION OF COVERAGE.—An account holder of a health opportunity account, after becoming ineligible for medical assistance under this title, is not required to purchase high-deductible or other insurance as a condition of maintaining or using the account.

''(4) ADMINISTRATION.—A State may coordinate administration of health opportunity accounts through the use of a third party administrator and reasonable expenditures for the use of such administrator shall be reimbursable to the State in the same manner as other administrative expenditures under section 1903(a)(7).

''(5) TREATMENT.—Amounts in, or contributed to, a health opportunity account shall not be counted as income or assets for purposes of determining eligibility for benefits under this title.

''(6) UNAUTHORIZED WITHDRAWALS.—A State may establish procedures—

''(A) to penalize or remove an individual from the health opportunity account based on nonqualified withdrawals by the individual from such an account; and

''(B) to recoup costs that derive from such nonqualified withdrawals.''.

SEC. 6083. STATE OPTION TO ESTABLISH NON-EMERGENCY MEDICAL TRANSPORTATION PROGRAM.

(a) IN GENERAL.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by sections 6033(a) and 6035(b), is amended—

(1) in paragraph (68), by striking ''and'' at the end;

(2) in paragraph (69) by striking the period at the end and inserting ''; and''; and

(3) by inserting after paragraph (69) the following:

''(70) at the option of the State and notwithstanding paragraphs (1), (10)(B), and (23), provide for the establishment of a non-emergency medical transportation brokerage program in order to more cost-effectively provide transportation for individuals eligible for medical assistance under the State plan

who need access to medical care or services and have no other means of transportation which—

"(A) may include a wheelchair van, taxi, stretcher car, bus passes and tickets, secured transportation, and such other transportation as the Secretary determines appropriate; and

"(B) may be conducted under contract with a broker who—

"(i) is selected through a competitive bidding process based on the State's evaluation of the broker's experience, performance, references, resources, qualifications, and costs;

"(ii) has oversight procedures to monitor beneficiary access and complaints and ensure that transport personnel are licensed, qualified, competent, and courteous;

"(iii) is subject to regular auditing and oversight by the State in order to ensure the quality of the transportation services provided and the adequacy of beneficiary access to medical care and services; and

"(iv) complies with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on the prohibitions on physician referrals under section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate).".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) take effect on the date of the enactment of this Act.

SEC. 6084. EXTENSION OF TRANSITIONAL MEDICAL ASSISTANCE (TMA) AND ABSTINENCE EDUCATION PROGRAM.

Effective as if enacted on December 31, 2005, activities authorized by sections 510 and 1925 of the Social Security Act shall continue through December 31, 2006, in the manner authorized for fiscal year 2005, notwithstanding section 1902(e)(1)(A) of such Act, and out of any money in the Treasury of the United States not otherwise appropriated, there are hereby appropriated such sums as may be necessary for such purpose. Grants and payments may be made pursuant to this authority through the first quarter of fiscal year 2007 at the level provided

for such activities through the first quarter of fiscal year 2006.

SEC. 6085. EMERGENCY SERVICES FURNISHED BY NON-CONTRACT PROVIDERS FOR MEDICAID MANAGED CARE ENROLLEES.

(a) IN GENERAL.—Section 1932(b)(2) of the Social Security Act (42 U.S.C. 1396u–2(b)(2)) is amended by adding at the end the following new subparagraph:

"(D) EMERGENCY SERVICES FURNISHED BY NON-CONTRACT PROVIDERS.—Any provider of emergency services that does not have in effect a contract with a medicaid managed care entity that establishes payment amounts for services furnished to a beneficiary enrolled in the entity's Medicaid managed care plan must accept as payment in full no more than the amounts (less any payments for indirect costs of medical education and direct costs of graduate medical education) that it could collect if the beneficiary received medical assistance under this title other than through enrollment in such an entity. In a State where rates paid to hospitals under the State plan are negotiated by contract and not publicly released, the payment amount applicable under this subpara-

graph shall be the average contract rate that would apply under the State plan for general acute care hospitals or the average contract rate that would apply under such plan for tertiary hospitals.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on January 1, 2007.

SEC. 6086. EXPANDED ACCESS TO HOME AND COMMUNITY-BASED SERVICES FOR THE ELDERLY AND DISABLED.

(a) HOME AND COMMUNITY-BASED SERVICES AS AN OPTIONAL BENEFIT FOR ELDERLY AND DISABLED INDIVIDUALS.—Section 1915 of the Social Security Act (42 U.S.C. 1396n) is amended by adding at the end the following new subsection:

''(i) STATE PLAN AMENDMENT OPTION TO PROVIDE HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND DISABLED INDIVIDUALS.—

''(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, a State may provide through a State plan amendment for the provision of medical assistance for home and community-based services (within the scope of services described in paragraph (4)(B) of subsection (c) for which the Secretary has the authority to approve a waiver and

not including room and board or such other services requested by the State as the Secretary may approve) for individuals eligible for medical assistance under the State plan whose income does not exceed 150 percent of the poverty line (as defined in section 2110(c)(5)), without determining that but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded, but only if the State meets the following requirements:

"(A) NEEDS-BASED CRITERIA FOR ELIGIBILITY FOR, AND RECEIPT OF, HOME AND COMMUNITY-BASED SERVICES.—The State establishes needs-based criteria for determining an individual's eligibility under the State plan for medical assistance for such home and community-based services, and if the individual is eligible for such services, the specific home and community-based services that the individual will receive.

"(B) ESTABLISHMENT OF MORE STRINGENT NEEDS-BASED ELIGIBILITY CRITERIA FOR INSTITUTIONALIZED CARE.—The State establishes needs-based criteria for determining

whether an individual requires the level of care provided in a hospital, a nursing facility, or an intermediate care facility for the mentally retarded under the State plan or under any waiver of such plan that are more stringent than the needs-based criteria established under subparagraph (A) for determining eligibility for home and community-based services.

''(C) PROJECTION OF NUMBER OF INDIVIDUALS TO BE PROVIDED HOME AND COMMUNITY-BASED SERVICES.—

''(i) IN GENERAL.—The State submits to the Secretary, in such form and manner, and upon such frequency as the Secretary shall specify, the projected number of individuals to be provided home and community-based services.

''(ii) AUTHORITY TO LIMIT NUMBER OF ELIGIBLE INDIVIDUALS.—A State may limit the number of individuals who are eligible for such services and may establish waiting lists for the receipt of such services.

''(D) CRITERIA BASED ON INDIVIDUAL ASSESSMENT.—

"(i) IN GENERAL.—The criteria established by the State for purposes of subparagraphs (A) and (B) requires an assessment of an individual's support needs and capabilities, and may take into account the inability of the individual to perform 2 or more activities of daily living (as defined in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986) or the need for significant assistance to perform such activities, and such other risk factors as the State determines to be appropriate.

"(ii) ADJUSTMENT AUTHORITY.—The State plan amendment provides the State with the option to modify the criteria established under subparagraph (A) (without having to obtain prior approval from the Secretary) in the event that the enrollment of individuals eligible for home and community-based services exceeds the projected enrollment submitted for purposes of subparagraph (C), but only if—

"(I) the State provides at least 60 days notice to the Secretary and

the public of the proposed modification;

''(II) the State deems an individual receiving home and community-based services on the basis of the most recent version of the criteria in effect prior to the effective date of the modification to be eligible for such services for a period of at least 12 months beginning on the date the individual first received medical assistance for such services; and

''(III) after the effective date of such modification, the State, at a minimum, applies the criteria for determining whether an individual requires the level of care provided in a hospital, a nursing facility, or an intermediate care facility for the mentally retarded under the State plan or under any waiver of such plan which applied prior to the application of the more stringent criteria developed under subparagraph (B).

''(E) INDEPENDENT EVALUATION AND ASSESSMENT.—

''(i) ELIGIBILITY DETERMINATION.—The State uses an independent evaluation for making the determinations described in subparagraphs (A) and (B).

''(ii) ASSESSMENT.—In the case of an individual who is determined to be eligible for home and community-based services, the State uses an independent assessment, based on the needs of the individual to—

''(I) determine a necessary level of services and supports to be provided, consistent with an individual's physical and mental capacity;

''(II) prevent the provision of unnecessary or inappropriate care; and

''(III) establish an individualized care plan for the individual in accordance with subparagraph (G).

''(F) ASSESSMENT.—The independent assessment required under subparagraph (E)(ii) shall include the following:

''(i) An objective evaluation of an individual's inability to perform 2 or more

activities of daily living (as defined in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986) or the need for significant assistance to perform such activities.

''(ii) A face-to-face evaluation of the individual by an individual trained in the assessment and evaluation of individuals whose physical or mental conditions trigger a potential need for home and community-based services.

''(iii) Where appropriate, consultation with the individual's family, spouse, guardian, or other responsible individual.

''(iv) Consultation with appropriate treating and consulting health and support professionals caring for the individual.

''(v) An examination of the individual's relevant history, medical records, and care and support needs, guided by best practices and research on effective strategies that result in improved health and quality of life outcomes.

''(vi) If the State offers individuals the option to self-direct the purchase of, or control the receipt of, home and commu-

nity-based service, an evaluation of the ability of the individual or the individual's representative to self-direct the purchase of, or control the receipt of, such services if the individual so elects.

''(G) INDIVIDUALIZED CARE PLAN.—

''(i) IN GENERAL.—In the case of an individual who is determined to be eligible for home and community-based services, the State uses the independent assessment required under subparagraph (E)(ii) to establish a written individualized care plan for the individual.

''(ii) PLAN REQUIREMENTS.—The State ensures that the individualized care plan for an individual—

''(I) is developed—

''(aa) in consultation with the individual, the individual's treating physician, health care or support professional, or other appropriate individuals, as defined by the State, and, where appropriate the individual's family, caregiver, or representative; and

"(bb) taking into account the extent of, and need for, any family or other supports for the individual;

"(II) identifies the necessary home and community-based services to be furnished to the individual (or, if the individual elects to self-direct the purchase of, or control the receipt of, such services, funded for the individual); and

"(III) is reviewed at least annually and as needed when there is a significant change in the individual's circumstances.

"(iii) STATE OPTION TO OFFER ELECTION FOR SELF-DIRECTED SERVICES.—

"(I) INDIVIDUAL CHOICE.—At the option of the State, the State may allow an individual or the individual's representative to elect to receive self-directed home and community-based services in a manner which gives them the most control over such services consistent with the individual's abili-

ties and the requirements of subclauses (II) and (III).

"(II) SELF-DIRECTED SERVICES.—The term 'self-directed' means, with respect to the home and community-based services offered under the State plan amendment, such services for the individual which are planned and purchased under the direction and control of such individual or the individual's authorized representative, including the amount, duration, scope, provider, and location of such services, under the State plan consistent with the following requirements:

"(aa) ASSESSMENT.—There is an assessment of the needs, capabilities, and preferences of the individual with respect to such services.

"(bb) SERVICE PLAN.—Based on such assessment, there is developed jointly with such individual or the individual's authorized representative a plan for

such services for such individual that is approved by the State and that satisfies the requirements of subclause (III).

"(III) PLAN REQUIREMENTS.—For purposes of subclause (II)(bb), the requirements of this subclause are that the plan—

"(aa) specifies those services which the individual or the individual's authorized representative would be responsible for directing;

"(bb) identifies the methods by which the individual or the individual's authorized representative will select, manage, and dismiss providers of such services;

"(cc) specifies the role of family members and others whose participation is sought by the individual or the individual's authorized representative with respect to such services;

"(dd) is developed through a person-centered process that is directed by the individual or the individual's authorized representative, builds upon the individual's capacity to engage in activities that promote community life and that respects the individual's preferences, choices, and abilities, and involves families, friends, and professionals as desired or required by the individual or the individual's authorized representative;

"(ee) includes appropriate risk management techniques that recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of such plan based upon the resources and capabilities of the individual or the individual's authorized representative; and

"(ff) may include an individualized budget which identifies the dollar value of the services and supports under the control and direction of the individual or the individual's authorized representative.

"(IV) BUDGET PROCESS.—With respect to individualized budgets described in subclause (III)(ff), the State plan amendment—

"(aa) describes the method for calculating the dollar values in such budgets based on reliable costs and service utilization;

"(bb) defines a process for making adjustments in such dollar values to reflect changes in individual assessments and service plans; and

"(cc) provides a procedure to evaluate expenditures under such budgets.

"(H) QUALITY ASSURANCE; CONFLICT OF INTEREST STANDARDS.—

"(i) QUALITY ASSURANCE.—The State ensures that the provision of home and community-based services meets Federal and State guidelines for quality assurance.

"(ii) CONFLICT OF INTEREST STANDARDS.—The State establishes standards for the conduct of the independent evaluation and the independent assessment to safeguard against conflicts of interest.

"(I) REDETERMINATIONS AND APPEALS.—The State allows for at least annual redeterminations of eligibility, and appeals in accordance with the frequency of, and manner in which, redeterminations and appeals of eligibility are made under the State plan.

"(J) PRESUMPTIVE ELIGIBILITY FOR ASSESSMENT.—The State, at its option, elects to provide for a period of presumptive eligibility (not to exceed a period of 60 days) only for those individuals that the State has reason to believe may be eligible for home and community-based services. Such presumptive eligibility shall be limited to medical assistance for carrying out the independent evaluation and as-

sessment under subparagraph (E) to determine an individual's eligibility for such services and if the individual is so eligible, the specific home and community-based services that the individual will receive.

''(2) DEFINITION OF INDIVIDUAL'S REPRESENTATIVE.—In this section, the term 'individual's representative' means, with respect to an individual, a parent, a family member, or a guardian of the individual, an advocate for the individual, or any other individual who is authorized to represent the individual.

''(3) NONAPPLICATION.—A State may elect in the State plan amendment approved under this section to not comply with the requirements of section 1902(a)(1) (relating to statewideness) and section 1902(a)(10)(C)(i)(III) (relating to income and resource rules applicable in the community), but only for purposes of provided home and community-based services in accordance with such amendment. Any such election shall not be construed to apply to the provision of services to an individual receiving medical assistance in an institutionalized setting as a result of a determination that the individual requires the level of care provided in a hospital or a nursing

facility or intermediate care facility for the mentally retarded.

''(4) NO EFFECT ON OTHER WAIVER AUTHORITY.—Nothing in this subsection shall be construed as affecting the option of a State to offer home and community-based services under a waiver under subsections (c) or (d) of this section or under section 1115.

''(5) CONTINUATION OF FEDERAL FINANCIAL PARTICIPATION FOR MEDICAL ASSISTANCE PROVIDED TO INDIVIDUALS AS OF EFFECTIVE DATE OF STATE PLAN AMENDMENT.—Notwithstanding paragraph (1)(B), Federal financial participation shall continue to be available for an individual who is receiving medical assistance in an institutionalized setting, or home and community-based services provided under a waiver under this section or section 1115 that is in effect as of the effective date of the State plan amendment submitted under this subsection, as a result of a determination that the individual requires the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded, without regard to whether such individuals satisfy the more stringent eligibility criteria established under that paragraph,

until such time as the individual is discharged from the institution or waiver program or no longer requires such level of care.''.

(b) QUALITY OF CARE MEASURES.—

(1) IN GENERAL.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality, shall consult with consumers, health and social service providers and other professionals knowledgeable about long-term care services and supports to develop program performance indicators, client function indicators, and measures of client satisfaction with respect to home and community-based services offered under State Medicaid programs.

(2) BEST PRACTICES.—The Secretary shall—

(A) use the indicators and measures developed under paragraph (1) to assess such home and community-based services, the outcomes associated with the receipt of such services (particularly with respect to the health and welfare of the recipient of the services), and the overall system for providing home and community-based services under the Medicaid program under title XIX of the Social Security Act; and

(B) make publicly available the best practices identified through such assessment and a comparative analyses of the system features of each State.

(3) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary of Health and Human Services, $1,000,000 for the period of fiscal years 2006 through 2010 to carry out this subsection.

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) take effect on January 1, 2007, and apply to expenditures for medical assistance for home and community-based services provided in accordance with section 1915(i) of the Social Security Act (as added by subsections (a) and (b)) on or after that date.

SEC. 6087. OPTIONAL CHOICE OF SELF-DIRECTED PERSONAL ASSISTANCE SERVICES (CASH AND COUNSELING).

(a) EXEMPTION FROM CERTAIN REQUIREMENTS.—Section 1915 of the Social Security Act (42 U.S.C. 1396n), as amended by section 6086(a), is amended by adding at the end the following new subsection:

''(j)(1) A State may provide, as 'medical assistance', payment for part or all of the cost of self-directed personal assistance services (other than room and board) under the

plan which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that, but for the provision of such services, the individuals would require and receive personal care services under the plan, or home and community-based services provided pursuant to a waiver under subsection (c). Self-directed personal assistance services may not be provided under this subsection to individuals who reside in a home or property that is owned, operated, or controlled by a provider of services, not related by blood or marriage.

''(2) The Secretary shall not grant approval for a State self-directed personal assistance services program under this section unless the State provides assurances satisfactory to the Secretary of the following:

''(A) Necessary safeguards have been taken to protect the health and welfare of individuals provided services under the program, and to assure financial accountability for funds expended with respect to such services.

''(B) The State will provide, with respect to individuals who—

''(i) are entitled to medical assistance for personal care services under the plan, or receive

home and community-based services under a waiver granted under subsection (c);

''(ii) may require self-directed personal assistance services; and

''(iii) may be eligible for self-directed personal assistance services,

an evaluation of the need for personal care under the plan, or personal services under a waiver granted under subsection (c).

''(C) Such individuals who are determined to be likely to require personal care under the plan, or home and community-based services under a waiver granted under subsection (c) are informed of the feasible alternatives, if available under the State's self-directed personal assistance services program, at the choice of such individuals, to the provision of personal care services under the plan, or personal assistance services under a waiver granted under subsection (c).

''(D) The State will provide for a support system that ensures participants in the self-directed personal assistance services program are appropriately assessed and counseled prior to enrollment and are able to manage their budgets. Additional

counseling and management support may be provided at the request of the participant.

''(E) The State will provide to the Secretary an annual report on the number of individuals served and total expenditures on their behalf in the aggregate. The State shall also provide an evaluation of overall impact on the health and welfare of participating individuals compared to non-participants every three years.

''(3) A State may provide self-directed personal assistance services under the State plan without regard to the requirements of section 1902(a)(1) and may limit the population eligible to receive these services and limit the number of persons served without regard to section 1902(a)(10)(B).

''(4)(A) For purposes of this subsection, the term 'self-directed personal assistance services' means personal care and related services, or home and community-based services otherwise available under the plan under this title or subsection (c), that are provided to an eligible participant under a self-directed personal assistance services program under this section, under which individuals, within an approved self-directed services plan and budget, purchase personal assistance and related services, and per-

mits participants to hire, fire, supervise, and manage the individuals providing such services.

''(B) At the election of the State—

''(i) a participant may choose to use any individual capable of providing the assigned tasks including legally liable relatives as paid providers of the services; and

''(ii) the individual may use the individual's budget to acquire items that increase independence or substitute (such as a microwave oven or an accessibility ramp) for human assistance, to the extent that expenditures would otherwise be made for the human assistance.

''(5) For purpose of this section, the term 'approved self-directed services plan and budget' means, with respect to a participant, the establishment of a plan and budget for the provision of self-directed personal assistance services, consistent with the following requirements:

''(A) SELF-DIRECTION.—The participant (or in the case of a participant who is a minor child, the participant's parent or guardian, or in the case of an incapacitated adult, another individual recognized by State law to act on behalf of the participant) exercises choice and control over the budget, planning, and purchase of self-directed personal assistance

services, including the amount, duration, scope, provider, and location of service provision.

''(B) ASSESSMENT OF NEEDS.—There is an assessment of the needs, strengths, and preferences of the participants for such services.

''(C) SERVICE PLAN.—A plan for such services (and supports for such services) for the participant has been developed and approved by the State based on such assessment through a person-centered process that—

''(i) builds upon the participant's capacity to engage in activities that promote community life and that respects the participant's preferences, choices, and abilities; and

''(ii) involves families, friends, and professionals in the planning or delivery of services or supports as desired or required by the participant.

''(D) SERVICE BUDGET.—A budget for such services and supports for the participant has been developed and approved by the State based on such assessment and plan and on a methodology that uses valid, reliable cost data, is open to public inspection, and includes a calculation of the expected cost of such services if those services were not self-directed.

The budget may not restrict access to other medically necessary care and services furnished under the plan and approved by the State but not included in the budget.

''(E) APPLICATION OF QUALITY ASSURANCE AND RISK MANAGEMENT.—There are appropriate quality assurance and risk management techniques used in establishing and implementing such plan and budget that recognize the roles and responsibilities in obtaining services in a self-directed manner and assure the appropriateness of such plan and budget based upon the participant's resources and capabilities.

''(6) A State may employ a financial management entity to make payments to providers, track costs, and make reports under the program. Payment for the activities of the financial management entity shall be at the administrative rate established in section 1903(a).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to services furnished on or after January 1, 2007.

Subtitle B—SCHIP

SEC. 6101. ADDITIONAL ALLOTMENTS TO ELIMINATE FISCAL YEAR 2006 FUNDING SHORTFALLS.

(a) IN GENERAL.—Section 2104 of the Social Security Act (42 U.S.C. 1397dd) is amended by inserting after subsection (c) the following:

''(d) ADDITIONAL ALLOTMENTS TO ELIMINATE FUNDING SHORTFALLS.—

''(1) APPROPRIATION; ALLOTMENT AUTHORITY.—For the purpose of providing additional allotments to shortfall States described in paragraph (2), there is appropriated, out of any money in the Treasury not otherwise appropriated, $283,000,000 for fiscal year 2006.

''(2) SHORTFALL STATES DESCRIBED.—For purposes of paragraph (1), a shortfall State described in this paragraph is a State with a State child health plan approved under this title for which the Secretary estimates, on the basis of the most recent data available to the Secretary as of December 16, 2005, that the projected expenditures under such plan for such State for fiscal year 2006 will exceed the sum of—

"(A) the amount of the State's allotments for each of fiscal years 2004 and 2005 that will not be expended by the end of fiscal year 2005;

"(B) the amount, if any, that is to redistributed to the State during fiscal year 2006 in accordance with subsection (f); and

"(C) the amount of the State's allotment for fiscal year 2006.

"(3) ALLOTMENTS.—In addition to the allotments provided under subsections (b) and (c), subject to paragraph (4), of the amount available for the additional allotments under paragraph (1) for fiscal year 2006, the Secretary shall allot—

"(A) to each shortfall State described in paragraph (2) such amount as the Secretary determines will eliminate the estimated shortfall described in such paragraph for the State; and

"(B) to each commonwealth or territory described in subsection (c)(3), the same proportion as the proportion of the commonwealth's or territory's allotment under subsection (c) (determined without regard to subsection (f)) to 1.05 percent of the amount appropriated under paragraph (1).

''(4) USE OF ADDITIONAL ALLOTMENT.—Additional allotments provided under this subsection are only available for amounts expended under a State plan approved under this title for child health assistance for targeted low-income children.

''(5) 1-YEAR AVAILABILITY; NO REDISTRIBUTION OF UNEXPENDED ADDITIONAL ALLOTMENTS.—Notwithstanding subsections (e) and (f), amounts allotted to a State pursuant to this subsection for fiscal year 2006 shall only remain available for expenditure by the State through September 30, 2006. Any amounts of such allotments that remain unexpended as of such date shall not be subject to redistribution under subsection (f) and shall revert to the Treasury on October 1, 2006.''.

(b) CONFORMING AMENDMENTS.—Section 2104 of the Social Security Act (42 U.S.C. 1397dd) is amended—

(1) in subsection (a), by inserting ''subject to subsection (d),'' after ''under this section,'';

(2) in subsection (b)(1), by inserting ''and subsection (d)'' after ''Subject to paragraph (4)''; and

(3) in subsection (c)(1), by inserting ''subject to subsection (d),'' after ''for a fiscal year,''.

(c) EFFECTIVE DATE.—The amendments made by this section apply to items and services furnished on or

after October 1, 2005, without regard to whether or not regulations implementing such amendments have been issued.

SEC. 6102. PROHIBITION AGAINST COVERING NONPREGNANT CHILDLESS ADULTS WITH SCHIP FUNDS.

(a) PROHIBITION ON USE OF SCHIP FUNDS.—Section 2107 of the Social Security Act (42 U.S.C. 1397gg) is amended by adding at the end the following:

''(f) LIMITATION OF WAIVER AUTHORITY.—Notwithstanding subsection (e)(2)(A) and section 1115(a), the Secretary may not approve a waiver, experimental, pilot, or demonstration project that would allow funds made available under this title to be used to provide child health assistance or other health benefits coverage to a nonpregnant childless adult. For purposes of the preceding sentence, a caretaker relative (as such term is defined for purposes of carrying out section 1931) shall not be considered a childless adult.''.

(b) CONFORMING AMENDMENTS.—Section 2105(c)(1) of such Act (42 U.S.C. 1397ee(c)(1)) is amended—

(1) by inserting ''and may not include coverage of a nonpregnant childless adult'' after ''section 2101)''; and

(2) by adding at the end the following: ''For purposes of the preceding sentence, a caretaker relative (as such term is defined for purposes of carrying out section 1931) shall not be considered a childless adult.''.

(c) RULE OF CONSTRUCTION.—Nothing in this section or the amendments made by this section shall be construed to—

(1) authorize the waiver of any provision of title XIX or XXI of the Social Security Act (42 U.S.C. 1396 et seq., 1397aa et seq.) that is not otherwise authorized to be waived under such titles or under title XI of such Act (42 U.S.C. 1301 et seq.) as of the date of enactment of this Act;

(2) imply congressional approval of any waiver, experimental, pilot, or demonstration project affecting funds made available under the State children's health insurance program under title XXI of the Social Security Act (42 U.S.C. 1397aa et. seq.) or any amendment to such a waiver or project that has been approved as of such date of enactment; or

(3) apply to any waiver, experimental, pilot, or demonstration project that would allow funds made available under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) to be used to provide

child health assistance or other health benefits coverage to a nonpregnant childless adult that is approved before the date of enactment of this Act or to any extension, renewal, or amendment of such a waiver or project that is approved on or after such date of enactment.

(d) EFFECTIVE DATE.—This section and the amendments made by this section shall take effect as if enacted on October 1, 2005, and shall apply to any waiver, experimental, pilot, or demonstration project that is approved on or after that date.

SEC. 6103. CONTINUED AUTHORITY FOR QUALIFYING STATES TO USE CERTAIN FUNDS FOR MEDICAID EXPENDITURES.

(a) IN GENERAL.—Section 2105(g)(1)(A) of the Social Security Act (42 U.S.C. 1397ee(g)(1)(A)) is amended by striking ''or 2001'' and inserting ''2001, 2004, or 2005''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to expenditures made under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) on or after October 1, 2005.

Subtitle C—Katrina Relief

SEC. 6201. ADDITIONAL FEDERAL PAYMENTS UNDER HURRICANE-RELATED MULTI-STATE SECTION 1115 DEMONSTRATIONS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall pay to each eligible State, from amounts appropriated pursuant to subsection (e), amounts for the following purposes:

(1) Under the authority of an approved Multi-State Section 1115 Demonstration Project (in this section referred to as an ''section 1115 project'')—

(A) with respect to evacuees receiving health care under such project, for the non-Federal share of expenditures:

(i) for medical assistance furnished under title XIX of the Social Security Act, and

(ii) for child health assistance furnished under title XXI of such Act;

(B) with respect to evacuees who do not have other coverage for such assistance through insurance, including (but not limited to) private insurance, under title XIX or title XXI of the Social Security Act, or under State-funded health insurance programs, for the total uncom-

pensated care costs incurred for medically necessary services and supplies or premium assistance for such persons, and for those evacuees receiving medical assistance under the project for the total uncompensated care costs incurred for medically necessary services and supplies beyond those included as medical assistance or child health assistance under the State's approved plan under title XIX or title XXI of the Social Security Act;

(C) with respect to affected individuals receiving health care under such project for the non-Federal share of the following expenditures:

(i) for medical assistance furnished under title XIX of the Social Security Act, and

(ii) for child health assistance furnished under title XXI of such Act; and

(D) with respect to affected individuals who do not have other coverage for such assistance through insurance, including (but not limited to) private insurance, under title XIX or title XXI of the Social Security Act, or under State-funded health insurance programs, for the total uncompensated care costs incurred for

medically necessary services and supplies or premium assistance for such persons, and for those affected individuals receiving medical assistance under the project for the total uncompensated care costs incurred for medically necessary services and supplies beyond those included as medical assistance or child health assistance under the State's approved plan under title XIX or title XXI of the Social Security Act.

(2) For reimbursement of the reasonable administrative costs related to subparagraphs (A) through (D) of paragraph (1) as determined by the Secretary.

(3) Only with respect to affected counties or parishes, for reimbursement with respect to individuals receiving medical assistance under existing State plans approved by the Secretary of Health and Human Services for the following non-Federal share of expenditures:

(A) For medical assistance furnished under title XIX of the Social Security Act.

(B) For child health assistance furnished under title XXI of such Act.

(4) For other purposes, if approved by the Secretary under the Secretary's authority, to restore access to health care in impacted communities.

(b) DEFINITIONS.—For purposes of this section:

(1) The term ''affected individual'' means an individual who resided in an individual assistance designation county or parish pursuant to section 408 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, as declared by the President as a result of Hurricane Katrina and continues to reside in the same State that such county or parish is located in.

(2) The term ''affected counties or parishes'' means a county or parish described in paragraph (1).

(3) The term ''evacuee'' means an affected individual who has been displaced to another State.

(4) The term ''eligible State'' means a State that has provided care to affected individuals or evacuees under a section 1115 project.

(c) APPLICATION TO MATCHING REQUIREMENTS.—The non-Federal share paid under this section shall not be regarded as Federal funds for purposes of Medicaid matching requirements, the effect of which is to provide

fiscal relief to the State in which the Medicaid eligible individual originally resided.

(d) TIME LIMITS ON PAYMENTS.—

(1) No payments shall be made by the Secretary under subsection (a)(1)(A) or (a)(1)(C), for costs of health care provided to an eligible evacuee or affected individual for services for such individual incurred after June 30, 2006.

(2) No payments shall be made by the Secretary under subsection (a)(1)(B) or (a)(1)(D) for costs of health care incurred after January 31, 2006.

(3) No payments may be made under subsection (a)(1)(B) or (a)(1)(D) for an item or service that an evacuee or an affected individual has received from an individual or organization as part of a public or private hurricane relief effort.

(e) APPROPRIATIONS.—For the purpose of providing funds for payments under this section, in addition to any funds made available for the National Disaster Medical System under the Department of Homeland Security for health care costs related to Hurricane Katrina, including under a section 1115 project, there is appropriated out of any money in the Treasury not otherwise appropriated, $2,000,000,000, to remain available to the Secretary until

expended. The total amount of payments made under subsection (a) may not exceed the total amount appropriated under this subsection.

SEC. 6202. STATE HIGH RISK HEALTH INSURANCE POOL FUNDING.

(a) IN GENERAL.—There are hereby authorized and appropriated for fiscal year 2006—

(1) $75,000,000 for grants under subsection (b)(1) of section 2745 of the Public Health Service Act (42 U.S.C. 300gg-45); and

(2) $15,000,000 for grants under subsection (a) of such section.

(b) TREATMENT.—The amount appropriated under—

(1) paragraph (1) shall be treated as if it had been appropriated under subsection (c)(2) of such section; and

(2) paragraph (2) shall be treated as if it had been appropriated under subsection (c)(1) of such section.

(c) REFERENCES.—Effective upon the enactment of the State High Risk Pool Funding Extension Act of 2005—

(1) subsection (a)(1) shall be applied by substituting ''subsections (b)(2) and (c)(3)'' for ''subsection ''(b)(1)'';

(2) subsection (b)(1) shall be applied by substituting ''(d)(1)(B)'' for ''(c)(2)''; and

(3) subsection (b)(2) shall be applied by substituting ''(d)(1)(A)'' for ''(c)(1)''.

SEC. 6203. IMPLEMENTATION FUNDING.

For purposes of implementing the provisions of, and amendments made by, title V of this Act and this title—

(1) the Secretary of Health and Human Services shall provide for the transfer, in appropriate part from the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), of $30,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for fiscal year 2006; and

(2) out of any funds in the Treasury not otherwise appropriated, there are appropriated to such Secretary for the Centers for Medicare & Medicaid Services Program Management Account, $30,000,000 for fiscal year 2006.